

# The San Diego County **Transgender** Assessment Report 2006



Jim Zians, Ph.D.  
Principle Investigator

A project of Family Health  
Centers Of San Diego's  
Transgender Health Project

Tracie Jada O'Brien  
Coordinator





Family Health Centers of San Diego would like to thank everyone involved in this historical undertaking. Special thanks go out to the volunteers from the Transgender community who took time out of their daily lives to recruit respondents for the assessment of the needs of San Diego County's Transgender community.

Special thanks are due to all the individuals who participated in the assessment.



**Transgender Needs Assessment Advisory Group:**

Jennifer Miller, AJ Czesky, Amanda Watson, Sue Ann Robbins, Christine Cummings, Connor Maddocks

**We would like to thank the following organizations for their participation and support:**

- The Transgender Community Coalition
- San Diego's LGBT Center
- The Imperial Court de San Diego
- The Tuesday Night Clinic
- The Hillcrest Youth Center
- The Hot Project
- My Own Advocate
- Transpire, San Diego
- Institute For Transgender Education
- And the members of San Diego's Transgender Community



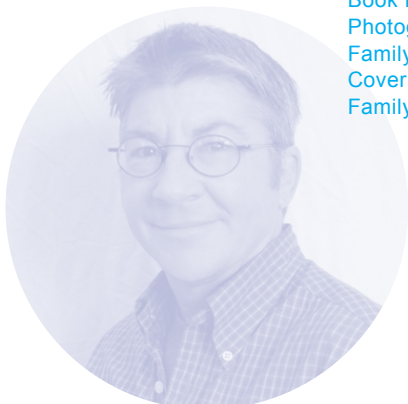
**Special Thanks go out to:**

- Amber Thorn, Dawn Media
- Sandra Ramirez, Latina TG support group Facilitator
- Jim Zians, Principal investigator
- Alberto Cortes and Bob Lewis for supporting the vision of the Transgender Community Coalition

This project made possible with the generous funding from The California Endowment Implemented by Family Health Centers Of San Diego's Transgender Health Project

Written by Jim Zians, Principal Investigator  
 Editor: Pauline Hovey  
 Research Consultant: Dr. Tom L. Smith

Book Design by Bryan Winke  
 Photographs by Clint Steib,  
 Family Health Centers of San Diego's Gay Men's Health Program  
 Cover Design by Robin Levy and Victoriano Diaz,  
 Family Health Centers of San Diego's HIV Services Marketing Team



# T A B L E O F C O N T E N T S

## Introduction

The Transgender Phenomenon and an Emerging Visibility . . . . .	3
A New Civil Rights Era in Healthcare . . . . .	5
The Need for Competent Healthcare in this Emerging Community Within Mainstream America . . . . .	5
Development of the Needs Assessment Instrument. . . . .	7

## Demographics

Age Distribution of Respondents . . . . .	7
Residency in San Diego County . . . . .	8
Education/Barriers Related to Gender Issues as a Youth. . . . .	9
Race and Ethnicity/Languages Spoken. . . . .	10
Living with a Disability . . . . .	11

## Employment

Annual Income/Finances/Homeownership . . . . .	12
Living Situation . . . . .	12
“Sky High” Unemployment Rates . . . . .	13
Issues Related to Preparedness for Employment . . . . .	13

## Transgender Identity

Terms and Identities . . . . .	15
Gender Identity . . . . .	16
With What Part of the Transgender Community Do You Identify? . . . . .	17
Sexual Orientation (see also section on Sexual Behavior of Transgender Respondents) . . . . .	19
“Openness” as a Transgender Person . . . . .	19
“The Passing Privilege” and “Openness” . . . . .	20
Age of “Openness” . . . . .	20
Marriage, Divorce, and Children . . . . .	21
“Openness” with Family, Friends, Co-workers, and Neighbors . . . . .	22
“Openness” with Medical Care Providers (see also section on Transgender Persons as Healthcare Consumers, Patients, and Clients). . . . .	23
Safety Issues Related to “Openness” . . . . .	24

Transgender Persons and Issues Surrounding Medical Surgery, Body Modification Procedures

- “Do You Ever Plan to Have Sex Reassignment Surgery (SRS)?” ..... 25
- Other Implications to Sex Reassignment Surgery (SRS) ..... 26
- Characteristics of Transgender Respondents: Current Anatomy, Body Modification and Hormone Therapy ..... 26
- The Internet as a Key Source of Information ..... 27

Transgender Persons as Healthcare Consumers—Patients and Clients

- Trust and Other Issues Concerning Healthcare Providers/Predictors  
of Healthcare Satisfaction, Confidence, and Optimal Care. .... 27
- Health Insurance/Access to Medical Care ..... 28

Mental Health Issues of Transgender Respondents

- History with Gays and Lesbians ..... 29
- “A Catch-Twenty-two” Situation: “Mental Health Professionals as “Gatekeepers” ..... 30
- The Harry Benjamin International Gender Dysphoria Association ..... 30
- Local Data on Transgender Persons’ Mental Health Services ..... 30
- Suicidal Ideation. .... 32
- Life Satisfaction/Social Support ..... 32
- Connection and Affiliation to LGBT Service Providers ..... 33

Health Concerns

- Health Conditions of Transgender Respondents in San Diego County ..... 34
- Alcohol and Illegal Drugs ..... 35
- Tobacco ..... 36
- HIV/AIDS and Transgender Health Issues ..... 36

Sexual Behavior of Transgender Respondents in San Diego County

- Are You Sexually Active?/ Do You Have a Primary Sexual Partner? ..... 39
- Other Sexual Partners ..... 39
- Sexual Risk Behavior (see also section on HIV/AIDS and Related Mental Health Issues) ..... 40
- The Transgender Sex Worker/Barriers to Needs Assessment Participation. .... 40

Recommendations: Prioritization of Service and Program Needs. .... 42

# THE SAN DIEGO TRANSGENDER HEALTHCARE NEEDS ASSESSMENT REPORT

## I N T R O D U C T I O N

### THE TRANSGENDER PHENOMENON

I t is not uncommon to see things on the streets of America today that were once thought to be “out of the norm.” A typical couple walking with their children on the streets of any large U.S. city could come face-to-face with a “cross-dresser,” a “drag queen,” or a post-operative transsexual. Yet, although such incidents are becoming more commonplace, if the so-called social-cultural norms of any typical American community were plotted on a continuum beginning with “the common,” “the normal,” and “the ordinary,” and ending with “the unique,” “the different,” and “the unusual,” it is likely that mainstream America would see the *transgender phenomenon* lying somewhere toward the latter end of this continuum.

In modern America, the daily exposure to diverse cultures, foreign customs, and alternative lifestyles may seem commonplace. Yet face-to-face exposure to a transgender person is *not* expected in mainstream society. It appears that the transgender phenomenon has not yet been integrated into a concept of the ever-changing notion of cultural diversity.

*continued*

The term *transgender person* became an “umbrella” term for an array of newly emerging, nontraditional, cultural-social roles involving deviating definitions of gender. This term was developed as an attempt to avoid clinical and medical interpretations of nonconformist views about gender. History has treated transgender persons poorly, imposing stigmas, ostracism, discrimination, violence, and labels of mental illness on this segment of the population. But what has not been evident is the enormous pain transgender individuals have endured as they have tried to develop a sense of who they are. Few people have heard the courageous stories of so many from the transgender community whose daily challenge is the achievement of a moment of authenticity that can be transformed into a resilient sense of self.

As transgender persons become more visible in communities across America, they represent a challenge to the traditional, stereotypical definitions of gender, and the response to this challenge by mainstream America often takes the form of transphobia (Finnegan & McNally 2002). Transphobia refers to the fear, hatred, prejudice, and social rejection shown toward those who do not conform to traditional gender roles and/or styles.

Instigated and fostered by the anxiety found in those who are uncomfortable with challenges to the social conventions of gender, transphobia manifests itself as a reactionary defense that is overly judgmental. It becomes a hostile reaction lacking perspective or empathy. Like other forms of social aggression, stigma and persecution, transphobia facilitates political disenfranchisement, social alienation, personal insecurity, and unnecessary emotional pain.

Given the available body of literature encompassing the study of transgender persons, one could conclude that research on *transgenderism* is emergent, a work in progress. Until recently, few professional journals or multicultural textbooks focused on transgender issues. Very little empirical data exist that accurately characterize transgender persons and capture their developmental life experiences (Carroll, Gilroy, & Ryan 2002).

This lack of objective data contributes to public opinion’s reliance on negative stereotypes, offensive myths, harsh innuendo, and other misperceptions for information. Without much-needed scientific study, those who treat, care for, or work with transgender persons have no objective data to use as a source of guidance. To date, no large-scale scientific studies exist that deal with the transgender phenomenon.

An examination of the experiences of transgender persons makes evident that both individually, and now as an emerging community, they have endured a lifelong struggle to better understand themselves. Transgender persons, like many disenfranchised groups, lack role models from whom they can learn. Most often, transgender persons lack conventional life passages that form a developmental map for more traditional phases of life such as socially sanctioned relationships, traditional marriage, an extended family, and children. Hence, there is a lack of life structure coming from the aggregate society that applies to the experiences of the transgender community as well as an overall lack of information.

Until recently, transgender persons suffered the greatest consequences from this lack of life structure and information, since few cultural rituals and educational experiences were available to them as a means to reflect upon their own life experiences. Without this there has been little to share with the larger transgender community.

In order to gain optimal health and a more enriched quality of life, transgender persons need to become a more enfranchised community. For this to occur, a chronicle of life histories mixed with research findings from objective social-scientific study is essential. Though this is beginning to occur, this lack of information has made it hard for transgender persons to bring meaning to their own history and better understand themselves. Lacking this information has made it difficult for transgender persons to project themselves into the larger community, explain their story, and bring about a better future. Overall, the transgender emergence into today’s American society remains a sparsely documented story of a misunderstood people.

## A NEW CIVIL RIGHTS ERA IN HEALTHCARE

The Stonewall Riots of 1969 in New York City is celebrated as the anniversary of the modern Lesbian, Gay, Bisexual, and Transgender (LGBT) civil rights movement. What is often overlooked about this important anniversary is its emphasis on the leadership role of transgender persons in the Stonewall story. The Stonewall Inn was a gay bar located alongside Sheridan Square on Christopher Street near Seventh Avenue crossing in New York City's Greenwich Village. Drag queens, cross-dressers, transvestites, transsexuals, and other transgender persons often frequented Stonewall Inn. It was also a place the New York City Police Department occasionally visited to perform aggressive surveillance work or raids. During that time there were laws prohibiting men from dressing in women's clothes and impersonating women, and women from dressing in men's clothes and impersonating men. It was common for the police to enforce these laws by entering known establishments where this behavior occurred.

On Friday, June 27, 1969, the day of Judy Garland's funeral, eight New York City police detectives (seven wearing plain clothes and one wearing a uniform) raided the Stonewall Inn. They arrested two bartenders, three drag queens, and a lesbian. Patrons were asked to leave, one at a time, and the police broke a few things in the bar and made a small mess.

Yet something very unusual happened that night. The customers (mostly transgender people and their friends) did not leave the area, but instead gathered in the street. Soon a jeering crowd became an angry mob. A riot ensued. It continued again the next night and four nights after that. A month later the first meeting was held of the Gay Liberation Front. The modern LGBT civil rights movement was born.

This movement for civil rights also created the context for the movement toward changes in healthcare for transgender persons. Despite the increasing visibility of transgender persons in America through increased focus in the national media, there has been little understanding of the transgender phenomenon, its recent emergence, and the overall experiences of transgender persons, particularly among the healthcare community. The U.S. medical community has an extensive history

of prejudice toward transgender clients. Transgenderism was considered to be a pathological condition, and this led to barriers to care (Dean et al. 2000, Hunter & Mallon 1998). Rather than receive proper care, transgender clients have been stigmatized, marginalized, and overly diagnosed.

As the visibility of transgender persons has increased in mainstream society, transgender leaders have attempted to facilitate a shift from the "pathology" often associated with gender identity issues toward a notion of gender "nonconformity" (Dean et al. 2000). Today, as this shift continues to occur, progress can be made toward the realization of a continuum of culturally respectful healthcare that meets the needs of this unique target group.

In 1999, the American Public Health Association proposed a set of new policy statements reflecting the public health needs of transgender persons in America. Entitled, *The Need for Acknowledging Transgender Individuals within Research and Clinical Practices*, this series of statements emphasized four main points that it addressed directly to the National Institutes of Health (NIH), the Center for Disease Control and Prevention (CDC), and all researchers and healthcare clinicians in the United States:

- Healthcare professionals should not equate transgender individuals with gay men or lesbians. Instead, these individuals should be categorized separately by using the labels (m to f) transgender person or (f to m) transgender person.
- Transgender clients should be referred to per the gender in which they identify. Healthcare professionals are encouraged not to force transgender persons to fit within rigid gender norms. Instead they should be sensitive to the lives of transgender persons and treat them with dignity and respect.
- Healthcare professionals need to increase awareness of the distinct healthcare needs of transgender persons.
- The NIH and the CDC should make resources available that will facilitate a better understanding of the health risks of transgender persons and the barriers this target group experiences within healthcare settings.

## THE NEED FOR COMPETENT HEALTHCARE FOR THIS EMERGING COMMUNITY WITHIN MAINSTREAM AMERICA

By the mid 1970s most Americans had never heard of a *transgender person* until the press popularized the story of Renne Richards, the professional tennis player who had undergone sex reassignment surgery. More than a decade earlier Christine Jorgensen, a transsexual who had sex reassignment surgery in 1952, had become the first publicized transsexual in modern American history. These two stories led to public discussion and curiosity for a while, but each story eventually dissipated. In both accounts the mainstream public moved on to other interests.

The emergence of a more visible transgender community in America was already underway in 1993, the year Brandon Teena, a female-to-male (f to m) transgender person, was murdered. Brandon Teena was raped and then murdered when two male acquaintances discovered he was biologically a “female.” These events caught the attention of the American press. The story was dramatized in the academy award-winning movie, *Boys Don’t Cry* (Pierce 1999).

In 1998, paramedics left Tyra Hunter, an African American male-to-female (m to f) transgender person, to die following a car accident. Why? The paramedics opened her pants and saw she had a penis (Carroll et al. 2002).

It is estimated that one transgender person is murdered every month, and another 60% of all transgender persons have, at one time in their lives, been victims of hate-related violence. Some surveys of transgender respondents show attempted suicide rates above 50%, and the U.S. National Coalition of Anti-violence Programs found that 20% of LGBT hate crimes resulting in murder are directed toward transgender persons (Canadian Union of Public Employees 2003). Transphobia is the source of much of this violence.

Transgender persons are also subject to hatreds imposed by homophobia. Homophobia is defined as hostility and discrimination against homosexuals. Homophobia is the more familiar cousin of transphobia. Unfortunately, for many, homophobia remains a catchall category for gender nonconformity. It remains the “grab bag” of bigotry toward sexual minorities.

Given that some transgender persons are more easily identified, or “stand out” among crowds of people, they unfortunately are easy targets for ridicule among homophobes.

From the 1980s new ways of looking at the social construction of human culture have allowed a reexamination of the interrelationships between birth gender, gender identity, and sexuality (Lev 2004). During this reexamination, an emerging transgender community began finding a voice and reaching an audience. This process has continued for more than a decade as the voices have gotten louder and more people have listened. And perhaps even more people are preparing to listen.

San Diego, like many larger cities across America, has an emerging transgender community, which is becoming more visible in neighborhoods throughout San Diego County. One important aspect of this “emergence” is the need for an objective assessment of the healthcare needs of this very important target group. It is long overdue.

In general, needs assessments attempt to take a scientific look at a “slice of life,” over a cross-section of time. Needs assessment surveys are developed mainly to focus on specific target populations and to ask individuals about who they are and how they are adjusting to society. Perhaps most importantly, a needs assessment survey asks, “How are you doing?”

The subject of this report, the needs assessment study conducted in San Diego County in 2004, demonstrates that the process of reexamining gender issues has begun on a local level. Neighborhood by neighborhood, trained outreach workers sought out local transgender residents and encouraged them to take the needs assessment survey. Scientific methods were applied to better characterize some of the important health-related nuances of San Diego’s transgender community. As this occurred, the voices of this emerging community were also beginning to be heard. Perhaps the main message, or “sound byte,” from this new voice was the following: “End the myth of two genders!”

The needs assessment study reinforced the fact that although transgender persons are neighbors to all San Diego County residents, they have been ignored. They live among us, yet remain invisible. They have been undiscovered. They have been strangers to us all. Perhaps that will now change with the publication of this report.

## DEVELOPMENT OF THE NEEDS ASSESSMENT INSTRUMENT

In most cases the staffs of healthcare service organizations are insufficiently trained to provide comprehensive, culturally appropriate care to transgender persons (Lev 2004). Few healthcare providers, particularly nonprofit community service providers, have the capacity to provide the unique services necessary to sustain the continuum of care and treatment for transgender persons (see also, “Transgender Persons and Issues Surrounding Medical Surgery and Body Modification Procedures”). Yet during the past six years, North Park Family Health Center, a clinic in central San Diego County that is part of Family Health Centers of San Diego, has become an exception to this rule. The Tuesday night clinic staff has begun to gain expertise in medical services specific to the welfare of transgender persons.

The idea of conducting a needs assessment for the transgender community in San Diego County began several years before the funding for this project. The idea started when a group of transgender clients began regularly visiting the Tuesday night clinic at the North Park Family Health Center. This Tuesday night clinic focused on general health care to the San Diego lesbian, gay, bisexual and transgender community with a strong focus on sexual health and on providing other low-cost healthcare for clients without health insurance. This clinic soon became a popular service site for transgender clients who found the staff at North Park Family Health Center respectful and trustworthy.

As some of the licensed medical staff, including physicians and nurses, began learning more about the healthcare needs and concerns of transgender clients, word spread within the transgender community, and more transgender clients sought the clinic’s services. Over time, the Tuesday night clinic became a place where transgender clients could receive necessary care unique to their needs.

In the fall of 2001, an advisory committee was formed consisting of transgender clients and healthcare staff to begin a dialogue between providers and transgender clients for the purpose of increasing culturally sensitive care and services to San Diego’s transgender community. The committee met regularly for the next 18 months, and in the process, created an

open dialogue between transgender clients and their healthcare providers. In addition, the first-ever local HIV prevention brochure targeted to transgender persons was produced in San Diego County.

In the summer of 2003, the leadership at Family Health Center of San Diego decided to seek funding to pay for increased services specific to their transgender clients. To prepare for this endeavor, the advisory committee assisted with the development of an empirically based needs assessment survey.

Funded by a grant from the California Endowment — a private healthcare foundation that funds programs throughout California—the San Diego County Transgender Health Project was launched. Outreach workers collected data from the transgender population between March 1, 2004 and September 30, 2004.

To be eligible to participate in the transgender needs assessment, the respondent had to identify him or herself as a transgender person or identify as a gender different than his or her birth gender (see also, “With What Part of the Transgender Community Do You Identify?”). Although the advisory committee at North Park Family Health Center provided leadership for this project, a project coordinator, Tracie Jada O’Brien, oversaw the project. In addition, five part-time surveyors volunteered to assist with survey recruitment, focus groups and key informant interviews. A total of 136 transgender persons took the needs assessment survey.

## DEMOGRAPHICS

### AGE DISTRIBUTION OF RESPONDENTS

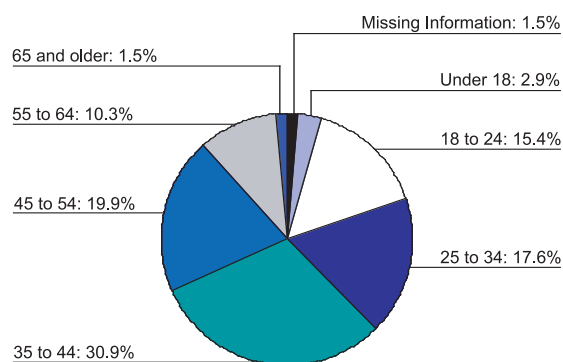
The average age of all survey respondents was 38.3 years (Figure 1). The ages of all respondents represented a range of 70 years, from ages nine to 79. The standard deviation for age was 13.10 demonstrating a broad representation among different ages. The median age of all respondents was 39 years.

For a number of analyses, the 136 respondents were divided into seven age groups: “under age 18” (2.9%, four respondents); “ages 19 to 24” (15.4%, 21 respondents); “age 25 to 34” (17.6%, 24 respondents); “age 35 to 44” (30.9%, 42

respondents); “ages 45 to 54” (19.9%, 27 respondents); “age 55 to 64” (10.3%, 14 respondents); “ages 65 and older” (1.5%, two respondents). Two respondents did not report their age.

Interestingly, four youth under age 18 participated in the survey; their ages were 9, 14, and 16 (two respondents). The nine-year-old respondent was accompanied by a parent and the survey was conducted at North Park Family Health Center. The three other youth were interviewed at local youth-based community agencies while under the supervision of agency staff. When youth identify as transgender, a diagnosis of gender identity disorder is often given. Controversy still exists today regarding whether gender identity disorder should be considered a mental health disorder (see section, “Mental Health Issues of Transgender Respondents”).

**Figure 1. Age Ranges of Transgender Needs Assessment Respondents (N = 136)**

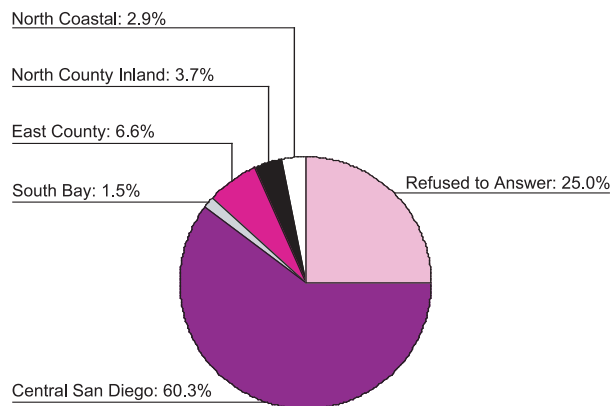


## RESIDENCY IN SAN DIEGO COUNTY

Respondents were asked how long they had lived in San Diego County. Their responses were divided into five categories: 1) less than one year, 2) one to two years, 3) three to five years, 4) five to 10 years, and 5) 11 years or more. Of the 135 respondents who answered this question, more than half reported they had lived in San Diego for 11 years or more (70 respondents). Of the remaining respondents, 14.1% had lived in San Diego for six to 10 years (19 respondents), 12.5% had lived in San Diego for three to five years (17 respondents), 8.9% had lived in San Diego for one to two years, and 12.6% percent had lived in San Diego for less than one year.

When asked for their residential zip code, 103 participants (76.7%) responded. The results revealed respondents lived in 38 different zip codes within a 60-mile radius of San Diego County. These zip codes show the percentage of respondents living in the following areas: Central San Diego or City of San Diego – 60.3% (70 respondents); South Bay – 1.5% (two respondents); East County – 6.6% (nine respondents); North County (Inland/noncoastal) – 3.7% (five respondents); North Coastal – 2.9% (four respondents). One respondent was a half-time resident of San Diego County. (Figure 2).

**Figure 2. Where Transgender Respondents Live in San Diego County (n = 136)**



Interestingly, nearly one-quarter of all respondents refused to report their zip code, although they were willing to report how long they had lived in San Diego (23.3%, 33 respondents). Given that the zip code was requested toward the beginning of the survey (question #2), and that other items toward the beginning of the survey showed similar incomplete responses, one conclusion might be that respondents were uncomfortable reporting the area where they live. A general lack of trust toward the mainstream community may be an explanation for high frequency rates of missing data on this question. It is important to note that as a subpopulation, transgender persons have experienced much stigma, prejudice, disenfranchisement, alienation, discrimination, and violence (see section on Mental Health Issues of Transgender Respondents).

## EDUCATION BARRIERS RELATED TO GENDER ISSUES AS A YOUTH

Focus groups conducted with survey respondents in September 2004 emphasized barriers to education. Participants in these focus groups stated that unresolved issues about being transgender that often occur during adolescence and early adulthood contribute to problems transgender persons often face in completing their education. Focus group participants identified eight areas that were common barriers to a transgender person successfully completing his or her education. Data from the 136 transgender respondents in these eight areas were the following: 1) discrimination (27.2%, 37 respondents); 2) not feeling comfortable in school (36%, 49 respondents); 3) being overwhelmed by transgender issues (25.7%, 35 respondents); 4) family dynamics (27.2%, 37 respondents); 5) violence at school related to being transgender (19.1%, 26 respondents); 6) finances diverted to transgender needs (9.6%, 13 respondents); 7) poor concentration in class (31.6%, 43 respondents); and 8) mental health problems (18.4%, 25 respondents).

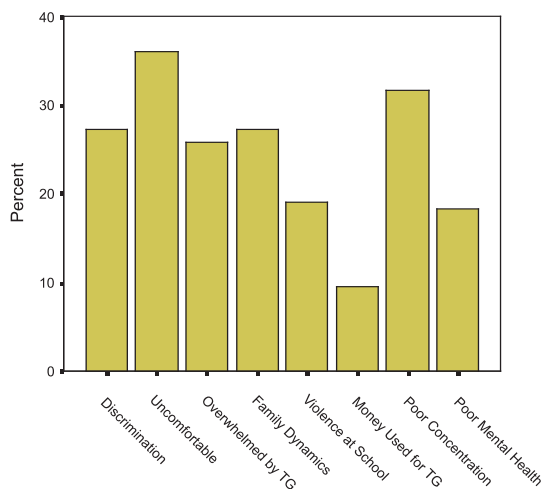
In reviewing responses from the 14 participants under age 21, it seems apparent that these eight issues remain current to transgender youth and young adults. When asked to identify barriers to successfully completing their education, the 14 youths responded as follows: 1) discrimination (28.6%, four respondents); 2) not feeling comfortable in school (64.3%, nine respondents); 3) being overwhelmed by transgender issues (28.6%, four respondents); 4) family dynamics (42.9%, six respondents); 5) violence at school related to being

transgender (21.4%, three respondents); 6) finances diverted to transgender needs (7.1%, one respondent); 7) poor concentration in class (42.9%, six respondents); and 8) mental health problems (28.6%, six respondents) (Figure 3).

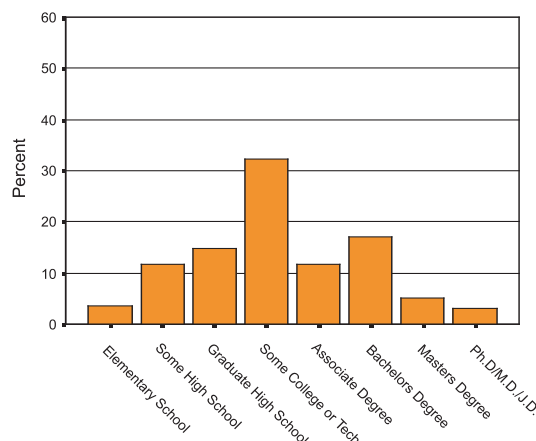
Needs assessment respondents were asked to record their highest level of formal education completed. Among the 135 respondents completing items related to education, 15.6% reported they did not graduate high school (21 respondents) and 14.8% reported they had a high school diploma (20 respondents). A majority of the respondents (69.8%) reported education beyond high school (114 respondents): 32.6% had completed some college or some technical training (44 respondents), 11.9% had completed an associate's degree or state certification (16 respondents), 17% had completed a bachelor's degree (23 respondents), 5.2% had completed a master's degree (seven respondents), and 3% had completed a post-master's degree, such as an M.D., Ph.D., or J.D. (four respondents) (Figure 4).

Although a majority of the respondents had some education beyond high school, a comparison of results with other studies of the LGBT community in San Diego County demonstrated that transgender persons might have a lower education level than the aggregate LGBT community. A 1998 needs assessment of San Diego County's LGBT community showed that 83% of all respondents reported education beyond high school (Estey & Bursaw 1998). A 2004 needs assessment of LGBT seniors (age 60 and older) in San Diego County also showed a higher number of respondents with education levels beyond high school, with 93% having technical training or higher, and 60.1% having a bachelor's degree or higher (Zians 2004).

**Figure 3. Education Barriers Related to Gender Issues Showing Youth and Young Adults Under Age 21 (n = 14)**



**Figure 4. Level of Education of Transgender Respondents (n = 135)**



Respondents were asked whether they needed financial aid services for education. Table 1. shows that 30.9% reported they “needed but had no access to these services” (42 respondents).

**Table 1. Need for Financial Aid Services for Education (N = 136)**

Need and have access	21
Don't Need	67
Need and No Access	42
Can't Afford	24
Need More Information	17
Services are Not LGBT Friendly	8
Services are Unavailable to Me	9

Finally, analyses were run to evaluate possible links to education barriers such as annual income, life satisfaction, and good mental health. There was a relationship between barriers to education and age, such that younger respondents were more likely than older respondents to assess that they had experienced education barriers ( $r = -.25, p = .003$ ). Additionally, barriers to education were related to income, such that experiencing greater barriers to education as a youth predicted lower income as an adult ( $r = -.20, p < .03$ ). Respondents under age 21 were not used in this analysis regarding education barriers and annual income.

Results also showed three other important relationships. First, the analyses showed a relationship between barriers to education and life satisfaction. Greater barriers to education as a youth predicted lower scores in life satisfaction ( $r = -.29, p = .03$ ). Second, a relationship was found between barriers to education related to gender issues in youth and good mental health, such that greater barriers to education were related to lower scores on the measure of good mental health ( $r = -.30, p < .001$ ) (see section, “Local Data on Transgender Persons’ Mental Health”). Finally, there was a relationship between barriers to education and barriers to employment, such that greater barriers to education predicted greater barriers to employment ( $r = .33, p < .001$ ) (see section, “Issues Related to Preparedness for Employment”).

## RACE AND ETHNICITY/LANGUAGES SPOKEN

According to demographic data for San Diego County, population rates for each racial/ethnic group are as follows: white/Caucasian (non-Hispanic) 58.5%, Hispanic/Latino 25%, Asian/Pacific Islander 10%, African American 5.3%, Native American 1.5% (San Diego Association of Governments [SANDAG] 2002).

One goal of the current project was to strategically target ethnically diverse members of the transgender community for the survey. The Transgender Health Project staff attempted to match the mix of respondents with the demographics for San Diego County. However, recruitment challenges often occur when attempting to solicit and include LGBT members of ethnic minority groups, such as Latinos, African Americans, Asian/Pacific Islanders, and Native Americans. These challenges were clearly present during recruitment for this project. Recruiting Latino/Latina and Asian/Pacific Islander transgender individuals presented the most difficulty. Recruitment of African American transgender individuals was more successful since the sample was larger than the expected local demographic of 5.3% (Figure 5). Unfortunately, barriers are often present when recruiting minorities within the LGBT community because they are more closeted and less likely to openly identify their gender orientation.

In the transgender survey, categories of race included “African American,” “Latino,” “White/non-Hispanic,” “Asian/Pacific Islander,” “Biracial,” “Native American,”

**Figure 5. Ethnicity of Transgender Respondents (n = 136)**

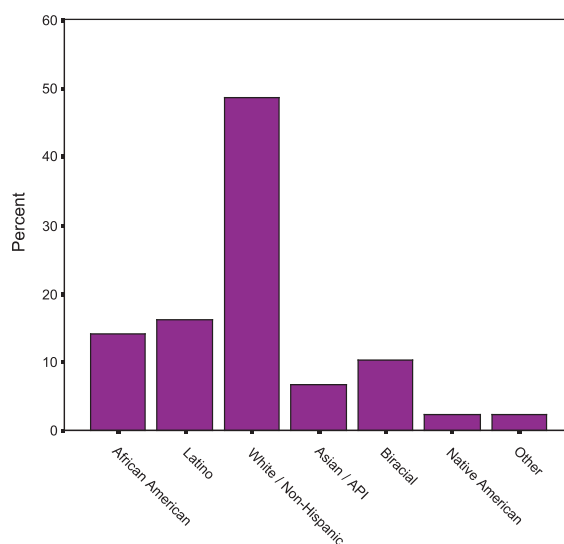


Table 2. Types of Disabilities of Respondents (n = 133)

Category (n = 38)	Number of Respondents	Ages 18 to 24	Ages 25 to 34	Ages 35 to 44	Ages 45 to 54	Ages 55 to 64	65 and older
HIV/AIDS	7			1	6		
Learning Disabled	3		1	1	1		
Respiratory	1						1
Mental Health	13		2	2	4	3	2
Physical Injury	1				1		
Deaf	1				1		
Neurological	1			1			
General Health	3				2	1	
Blindness	1					1	
Rheumatoid Arthritis	1						1
Veteran-Related Disability	2				2		
Not Specified	4				2	1	1

and “Other.” As seen in Figure 5, slightly less than half of all respondents were White/Caucasian at 48.5% (66 respondents), while other respondents included Latinos at 16.2% (22 respondents), African Americans at 14% (19 respondents), Asian/Pacific Islanders at 6.6% (nine respondents), Native Americans at 2.2% (three respondents), Biracial at 10.3% (14 respondents), and Other at 2.2% (three respondents).

When asked about languages they spoke (aside from English) respondents most often cited an ability to speak Spanish (21.3%, or 29 respondents). Seven respondents (5.1%) were monolingual Spanish. These monolingual respondents required a Spanish-speaking interpreter in order to complete the needs assessment survey. Two respondents spoke Tagalog; eight respondents reported they were able to speak another language such as French (one respondent) or German (one respondent). The remaining six respondents did not specify what language other than English they spoke.

## LIVING WITH A DISABILITY

Of the 133 respondents who answered survey items regarding “being disabled,” 28.6% reported that they were disabled (38 respondents). The average age for the disabled respondents was 42.2 years. The majority of disabled respondents (50%) were 35 to 44 years old (19 respondents). Types of disabilities reported were divided into 12 categories (Table 2): 1) HIV/AIDS, 2) learning disabilities, 3) respiratory problems, 4) mental health problems, 5) physical injury, 6) deafness, 7) neurological problems, 8) general health problems, 9) blindness, 10) rheumatoid arthritis, 11) veteran-related disability, and 12) not specified.

Transgender respondents who reported that they were

disabled were more likely to report having mental health concerns ( $t = 2.6$ ,  $df = 77.8$ ,  $p = .01$ , [t-test for unequal variances]), with 14 respondents (36.8%) citing this as the reason for their disability. Related to these mental health problems, respondents reported experiencing feelings of depression (65.8%, 25 respondents), dwelling on problems (60.5%, 23 respondents), having poor self-esteem (50%, 19 respondents), experiencing quick mood changes (47.4%, 18 respondents), feeling suicidal (44.7%, 17 respondents), drawing away from people (44.7%, 17 respondents), feeling negative about the future (42.1%, 16 respondents), and being unable to control one’s thoughts (26.3%, 10 respondents).

Although a large number of respondents who were disabled reported suicidal ideation, being disabled did not predict whether a respondent was suicidal ( $t = .67$ ,  $df = 123$ ,  $p = .50$ ). Unfortunately, among the entire sample of 136 participants, a high number reported suicidal ideation (31.6%, 43 respondents). This generally high rate of suicidal ideation, remains a leading concern to healthcare and LGBT community leaders in San Diego County (see section, “Recommendations #4) Mental Health/Suicide Prevention”).

Additional analyses regarding disabled transgender respondents revealed other concerns: 42.1% reported having problems walking (16 respondents) and 42.1% reported having problems breathing (16 respondents). Also, there was a relationship between being disabled and annual income, such that reporting a disability was related to a lower annual income ( $r = -.26$ ,  $p = .002$ ). More than three-fourths of disabled respondents, or 78.9%, reported having financial problems (30 respondents).

The disabilities the 38 transgender respondents specified having and their corresponding age groups are listed in Table 2.

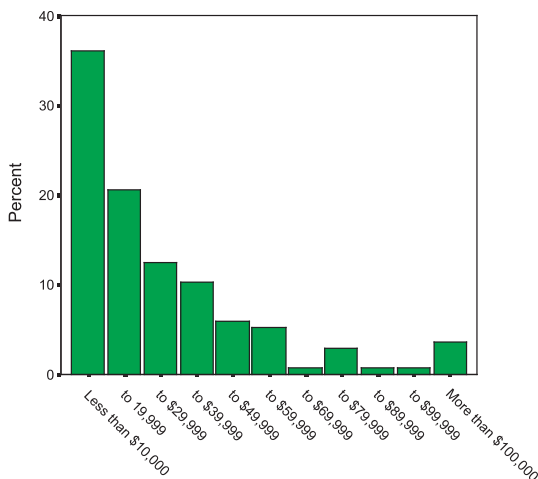
# EMPLOYMENT

## ANNUAL INCOME/FINANCES/HOME OWNERSHIP

According to the U. S. Census Bureau, the median household income in San Diego County for 1999 was \$47,067, and the average household was estimated to have 2.73 persons. The average per capita income for a person working in San Diego County in 1999 was \$22,926 (U.S. Census Bureau, California Quick Facts 2003). SANDAG (2002) reported that the median household income in San Diego County in 1998 was \$42,357, and only 7.2% of households countywide had an income of less than \$10,000 per year.

Most transgender individuals taking the needs assessment survey in 2004 reported incomes in the lowest income bracket, less than \$10,000 a year (36.3%, 49 respondents), and more than half (57%) had incomes below \$20,000 a year (Figure 6). These incomes are particularly low when noting that the average age of transgender respondents is 38.3 years. Other annual incomes reported were \$10,000 to \$19,999 (20.7%, 28 respondents), \$20,000 to \$29,999 (12.6%, 17 respondents), \$30,000 to \$39,999 (10.4%, 14 respondents), \$40,000 to \$49,999 (5.9%, eight respondents), and \$50,000 to \$59,999 (5.2%, seven respondents). Only 8.8% of all transgender respondents reported incomes above \$60,000 per year (12 respondents). Five of those 12 respondents reported incomes greater than \$100,000 per year. One respondent gave no information about annual income.

Figure 6. Annual Income for 2004 (n = 134)



Overall these incomes are lower than average for San Diego County residents. These low incomes are also noted in the context of the high rate of respondents who were disabled (27.9%, 38 respondents). Almost half of these disabled respondents (44.7%) reported incomes of less than \$10,000 per year (17 respondents), while another 31.6% reported incomes between \$10,000 and \$20,000 per year (12 respondents).

Survey participants were asked to give information about financial resources other than income, such as assets and savings. Consistent with those who have below-average incomes, transgender respondents reported having few other financial resources. Of the 111 respondents who answered items pertaining to financial resources other than income, more than three-fourths reported having additional financial resources of less than \$10,000 (86 respondents), and 9.9% reported having financial resources between \$10,000 and \$25,000. Twenty-five respondents gave no information about financial resources other than income.

Home ownership in San Diego County stands between 59.1% to 67.4%, well below the national average, and the cost of housing in the county has caused some leaders to refer to the situation as a housing crisis. Rent in San Diego County continues to increase steadily each year, and the vacancy rate is a slim 2% (SANDAG 2002). Among the 136 transgender respondents who reported information about their housing situation, only 17.6% reported owning their own home (24 respondents). One respondent reported owning a second home. Of these 24 homeowners, only two respondents reported that their mortgages were paid off. Homeowners' mortgage payments ranged from \$575 per month to \$2,500 per month, with an average of \$1,422.

Renters comprised 72.8% of the respondents, and rent payments ranged from \$250 per month to \$3,000 per month, with an average payment of \$680 per month. Three respondents reported being homeless (see sections, "Living Situation" and "Safety Issues Related to 'Openness'").

## LIVING SITUATION

Of the 133 respondents who completed survey items about their living situation, the majority (52.6%) live independently (70 respondents). Other living situations include 25.6%

who live with friends (34 respondents), 15.8% who live with their biological families (21 respondents), 2.3% who are homeless (three respondents), 1.5% who have an assisted living situation (two respondents), and 0.8% who live in a senior care facility (one respondent). Two respondents reported an “other” living situation, but they did not specify any details.

Additionally, 21.8% reported that they live with a roommate who is also their sexual partner (29 respondents), while 30.1% reported they live with a roommate who is not a sexual partner (40 respondents). Another 29.3% reported they live alone (39 respondents).

Respondents who did not have their own living space (either homeownership or a rental property) were asked to report problems they experienced regarding their living situation. They listed the following as barriers to acquiring their own living space: “economic problems” (24 respondents), “lack of affordable housing” (21 respondents), “lack of employment” (15 respondents), “estrangement from birth family” (eight respondents), and “others are insensitive/hostile toward transgender persons” (eight respondents).

Respondents were asked whether they needed assistance regarding housing discrimination. Table 3 shows that 14.7% reported they “needed but had no access to these services” (20 respondents).

**Table 3. Need for Assistance Regarding Housing Discrimination (N = 136)**

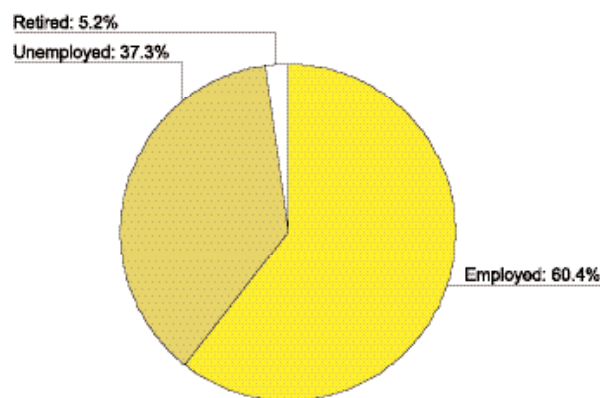
Need and have access	1
Don't Need	105
Need and No Access	20
Can't Afford	8
Need More Information	17
Services are Not LGBT Friendly	7
Services are Unavailable to Me	3

### “SKY HIGH” UNEMPLOYMENT RATES

As of November 2004, San Diego County had one of the lowest unemployment rates in the nation at 3.2%. The unemployment rate for the state of California during the same time period was 5.2%, and for the nation, it was 4.7% (Venturi Staffing Partners November 2004).

Results of the needs assessment survey show “sky high” unemployment among the transgender survey respondents. This appears to be a very serious problem since unemployment rates are more than 10 times higher for the transgender respondents than the average rate for all county residents. Of the 134 respondents who completed questions regarding employment, 37.3% reported that they were unemployed (50 respondents), 9% reported they were employed part-time (12 respondents), and only 5.2% reported that they were retired (seven respondents), and these retired respondents were not counted as unemployed (Figure 7).

**Figure 7. “Are You Currently Employed or Retired?” (n = 134)**

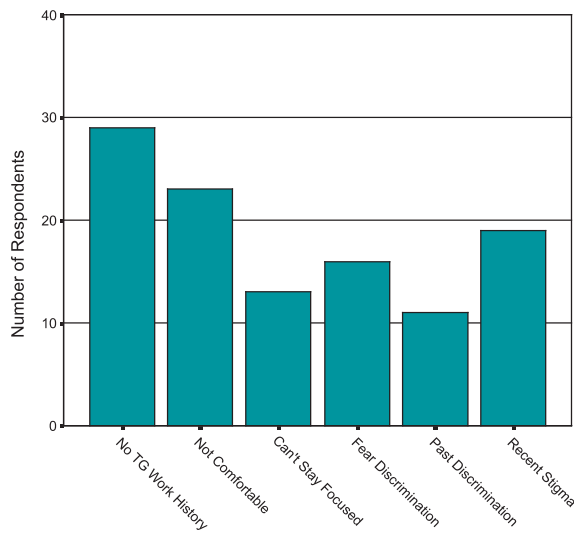


### ISSUES RELATED TO PREPAREDNESS FOR EMPLOYMENT

Employment problems and social issues in the workplace may serve as barriers to successful employment for transgender persons. Some survey items inquired about the relationship between employment and issues of transgender identity, self-acceptance, mental health, and workplace discrimination. Results show that transgender persons may struggle with many issues that make them unprepared for successful employment (Figure 8).

Issues surrounding transgender identity and self-acceptance may serve as barriers to employment. Of the 134 respondents who completed survey items about employment, 21.6% reported that they lacked a work history under their current identity as a transgender person (29 respondents), and 17.2% reported that they did not feel comfortable with themselves

**Figure 8. Number of respondents reporting barriers to employment they experienced as a transgender person. (n = 134)**



when in the workplace (23 respondents). Being able to stay focused when at work was a problem for 9.7% (13 respondents) and 14.2% had experienced workplace discrimination related to being transgender (19 respondents). Discrimination may prevent many transgender respondents from reentering the workforce; 12.7% of respondents reported that they avoid employment because they expect to experience discrimination in the workplace (17 respondents), 8.2% reported that they avoid employment because they experienced workplace discrimination in the past (11 respondents), and 14.2% reported that they recently experienced stigma related to transgender issues while in the workplace (19 respondents).

Respondents were asked whether they needed employment benefit services to assist them with employment challenges. Table 4 shows that 22.8% reported they “needed but had no access to these services” (31 respondents).

An overall composite score for “preparedness for employment” was developed using six items that inquired about barriers to employment. The individual items were “yes”

**Table 4. Need for Employment Benefit Services (N = 136)**

Need and have access	18
Don't Need	76
Need and No Access	31
Can't Afford	10
Need More Information	15
Services are Not LGBT Friendly	7
Services are Unavailable to Me	8

or “no” questions about problems in the workplace related to transgender identity issues, self-acceptance, ability to focus on job tasks, and issues of workplace discrimination. Respondents were asked to check these items if the barrier to employment applied to them.

Using a composite measure assessing whether respondents experienced barriers to their employment due to gender issues, an analysis was conducted to see if these barriers predicted other outcomes. The analysis found a relationship between preparedness for employment and good mental health, such that low scores on preparedness for employment were related to low scores on good mental health ( $r = .20, p < .02$ ).

Respondents were asked whether they needed services to assist with workplace discrimination. Table 5 shows that 23.5% reported they “needed but had no access to these services” (32 respondents).

**Table 5. Need for Assistance with Workplace Discrimination (N = 136)**

Need and Have Access	9
Don't Need	86
Need and No Access	32
Can't Afford	14
Need More Information	25
Services are Not LGBT Friendly	5
Services are Unavailable to Me	4

## TRANSGENDER IDENTITY

*“When I first came out I thought I was a gay man, and so I was trying to identify with the gay man. I have always been a quick study on everything, so I found out I wasn't a gay man...then I saw my first drag queen. I started doing performance and hanging out with entertainers and performers, but I said no, this is not where I am. And then shortly after that I met my first transgender person, and then at that point in my life I said ‘wow!’ I said this is who I am, this is what I am, this is where I fit in and this is where I feel comfortable. And from that point on in my life, ya know, there was no stopping me.”*

— Transgender Focus Group Participant, Sept. 30, 2004

## TERMS AND IDENTITIES

According to Lev (2004), the term transgender is an inclusive term derived from the transgender liberation movement. This liberation movement represents an integration of clinical, psychological, and political issues important to the overall civil rights and welfare of gender-variant individuals (see section, “A New Civil Rights Era”). The term transgender acts as an umbrella term that is often used to capture a continuum of gender identities that lie between the polarities of male versus female. Within this culture it is believed that gender encompasses a diverse range of gender identities that vary among its subgroups (Lev 2004).

The term “transsexual” is also difficult to clearly define. This term usually refers to individuals who believe that there is a discrepancy between their biological sex and their “true gender” (Shapiro 1991). Others have attempted to take the emphasis off of “biological” and “genital” definitions and have redefined “transsexual” as a label to include anyone who lives, has lived, or desires to live, either full-time or part-time, in a gender role that varies from their sex as defined at birth (Whittle 1995, as cited in Lev 2004). Such a definition would include individuals who sometimes alter their appearance to pose as the opposite sex for the purpose of relaxation or enjoyment yet who may not consider themselves to be transsexual. Also, those who have undergone surgery to possess physical characteristics of their “true gender” often cease to continue to consider themselves “transsexual” (Lev 2004).

Given these complications, the term “transsexual” was not used as an identifying term in the Transgender Healthcare Needs Assessment Survey. Instead, eight other subgroup identities were specified within the transgender continuum. Transgender respondents were asked to specify their identity within the transgender community using the following eight subgroups: 1) “cross-dresser,” 2) “transvestite,” 3) “drag queen,” 4) “drag king,” 5) “pre-operative,” 6) “post-operative,” 7) “non-operative,” or 8) “no hormones.”

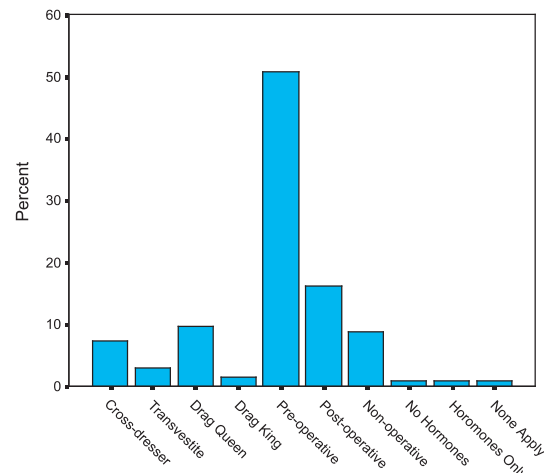
Cross-dressers usually do not consider themselves as transsexuals. These individuals dress in clothing of the opposite sex for enjoyment. They usually do not desire to alter their bodies via hormones or surgery, but rather wear garments or body augmentation devices (e.g., body padding, fake breasts) to temporarily change their appearance. The activity of males

cross-dressing as women has often be seen identified as a homosexual phenomenon. However, male cross-dressers, although sometimes homosexual, are most often heterosexual men with no affiliation to gay political movements or homosexual clinical issues (see also terms “drag queen” and “drag king” below). According to Lev (2004), the connotation that cross-dressing is linked to homosexuality is a mischaracterization most often made by a misguided medical community that mistakenly lumps the two groups together.

The term “transvestite” has a similar definition, both behaviorally and clinically, to the term “cross-dresser.” For some, the difference appears to be only a matter of language, social assimilation, and identity. Some contrast the transvestite with the cross-dresser through the function of the activity, whether it is for gender expression, entertainment, sexual satisfaction, or political purposes. Others state that “cross-dresser” is the preferred term. More recently, transvestites in the United States appear to prefer the term “cross-dresser” (Finnegan & McNally 2002 Lev 2004). There were 14 respondents who identified as either a transvestite or cross-dresser. Of these 14 respondents, 10 identified as a “cross-dresser,” while only four identified as a “transvestite” (Figure 9).

Drag queens have been defined as male cross-dressers who wear women’s clothing, yet do not attempt to “pass” as a woman. The term “passing privilege” is often used to depict a transgender person who, through clothing, cosmetics,

**Figure 9. With What Part of the Transgender Community Do You Identify? (n = 134)**



hormone use, or surgery, can travel though life virtually undetectable as anything other than their biologically assigned gender.

Drag kings are identified in a similar way to drag queens. They are defined as female cross-dressers who wear men’s clothing, yet do not attempt to “pass” as a man. According to Finnegan & McNally (2002), drag queens and drag kings usually cross-dress as a way to entertain others or to make socio-political statements.

Some transgender persons use the terms “pre-operative,” “post-operative,” or “non-operative” as a way to identify themselves within the transgender community. The term “pre-operative” is usually used to refer to transgender persons who desire to someday have “sex reassignment surgery” (SRS). When someone identifies as “pre-operative,” they are usually already preparing and/or planning for their surgery. “Post-operative” refers to those who have already undergone SRS. It should be noted that some “post-operatives” still plan additional surgeries in the future, such as those who have had surgical breast implants, but have not yet undergone surgical vaginal construction. Also, some “post-operatives” consider themselves part of the male or female gender group, and thus they no longer identify as a transgender person. On the other hand, the term “non-operative” usually refers to those transgender persons who do not identify either as a cross-dresser or a transvestite, who do intend to attain a “passing privilege” yet do not desire surgery.

Two additional terms are sometimes used as means of identification within the transgender community: “hormones only” and “no hormones.” Some transgender persons may prefer these terms based on whether or not they use hormone treatments.

## GENDER IDENTITY

Until recently the notion of gender received little conscious attention. For the medical community and all of society, gender involved a simple labeling process in compliance with the natural order of all things. A child was born either a boy or a girl. Babies had either a penis or a vagina. It was a “no brainer!”

Today, new information is evident. The term *intersex*, which refers to a condition where congenital abnormalities of the reproductive system are present, is now emerging as a more commonly known term, since new research shows that approximately 2% of all births can be categorized under conditions considered to be intersex. Although the anomaly varies with each case, some conditions involve “genital ambiguity” (Lev 2004). It appears that these conditions have been present throughout the ages, but silence regarding this subject has been just as enduring. The emerging visibility of the transgender community worldwide is changing this.

Survey participants were asked two questions about their gender identity. First, “What was your gender at birth?” Responses were “male,” “female,” “intersexed assigned male,” “intersexed assigned female,” and “intersexed not assigned.” Of the 136 respondents who answered this survey question, 83.1% were biologically assigned “male” at birth (112 respondents), 15.4% were biologically assigned “female” at birth (21 respondents), and 1.2% were “intersexed assigned male” at birth (two respondents).

Next, respondents were asked: “What gender do you identify with?” Choices included the following: “transgendered,” “male,” “female,” “androgynous,” and “questioning.” The term “androgynous” refers to individuals who prefer a blending of

**Table 6. Current Gender Identity Compared with Gender Biologically Assigned at Birth**

Current Gender Identity	Assigned “Male” at Birth	Assigned “Female” at Birth	At Birth “Intersexed Assigned Male”	TOTAL
Female	56	0	1	<b>57</b>
Male	7	16	0	<b>23</b>
Transgendered	43	4	0	<b>47</b>
Androgynous	4	0	1	<b>5</b>
Questioning	3	1	0	<b>4</b>
<b>TOTAL</b>	<b>113</b>	<b>21</b>	<b>2</b>	<b>136</b>

gender identity such that neither a clear-cut masculinity nor a clear-cut femininity is evident. Individuals who are “questioning” are still unsure about the gender to which they identify.

All 136 respondents completed this survey item. Results showed that the greatest number of respondents (41.9%) identified as “female” (57 respondents), while 34.6% identified as “transgendered” (47 respondents), 16.9% identified as “male” (23 respondents), 3.7% identified as “androgynous” (five respondents), and 2.9% identified as “questioning” (four respondents) (Table 6).

Table 6 demonstrates the breakdown of gender identity biologically assigned at birth compared with the respondent’s current gender identity. All 136 respondents answered items pertaining to this section. Of the 113 respondents who were assigned “male” at birth, 49.6% currently identified as “female” (56 respondents), 38.1% currently identified as “transgendered” (43 respondents), 6.2% maintained their birth identity as “male” (seven respondents), 3.5% currently identified as “androgynous” (four respondents), and 2.7% currently identified as “questioning” (three respondents). Of the 21 respondents who were assigned “female” at birth, 76.1% currently identified as “male” (16 respondents), 19% currently identified as “transgendered” (four respondents), and one currently identified as “questioning.” Finally, of the two respondents who were “intersexed assigned male” at birth, one respondent currently identified as “female,” and one respondent currently identified as “androgynous.”

## WITH WHAT PART OF THE TRANSGENDER COMMUNITY DO YOU IDENTIFY?

Of the 134 respondents who answered questions regarding transgender community identity, the majority (51.1%) identified as “pre-operative” (69 respondents), while 16.3% reported they were “post-operative” (22 respondents), 11.1% identified as either a “drag queen” (13 respondents) or “drag king” (two respondents), 10.4% identified as either a “cross-dresser” (10 respondents) or a “transvestite” (four respondents), 8.9% identified as “non-operative” (12 respondents), one respondent identified as “hormone only,” one respondent identified as “no hormones,” and one respondent reported that “none [of these identifying labels] apply” (Figure 9). One respondent gave no response to this survey item.

Table 7 shows the relationship between the respondent’s biologically assigned gender and his or her current transgender community identification. All but one respondent answered survey items pertaining to this section (135 respondents). Of the 112 respondents who were biologically assigned “male” at birth, 47.3% currently identified as “pre-operative (53 respondents), 16.1% identified as post-operative (18 respondents), 11.6% identified as a “drag queen” (13 respondents), 9.8% identified as “non-operative” (11 respondents), 8.9% identified as “cross-dresser” (10 respondents), 3.6% identified as “transvestite” (four respondents), one respondent identified as “hormones only,” one identified as “no hormones,” and two reported that none of these labels applied.

**Table 7. Gender Assigned at Birth vs. Current Transgender Community Identification (N= 136)**

Part of Transgender Community	Assigned Male at Birth	Assigned Female at Birth	Intersexed Assigned Male	Total
Cross-dresser	10	0	0	<b>10</b>
Transvestite	4	0	0	<b>4</b>
Drag Queen	13	0	0	<b>13</b>
Drag King	0	2	0	<b>2</b>
Pre-operative	53	15	1	<b>69</b>
Post-operative	18	4	0	<b>22</b>
Non-operative	11	0	1	<b>12</b>
No Hormones	1	0	0	<b>1</b>
Hormones Only	1	0	0	<b>1</b>
None Apply	2	0	0	<b>2</b>
<b>TOTAL</b>	<b>113</b>	<b>21</b>	<b>2</b>	<b>136</b>

**Table 8. Relationship Between Sexual Orientation, Birth Gender and Current Gender Identification (n = 135)**

Sexual Orientation	Assigned at Birth	Current Gender Identification	TOTAL
Straight/Heterosexual	Male at birth	Identify as Female	28
Straight/Heterosexual	Male at birth	Identify as Transgender	18
Bisexual	Male at birth	Identify as Male	11
Straight/Heterosexual	Female at birth	Identify as Male	10
Bisexual	Male at birth	Identify as Female	10
Lesbian	Male at birth	Identify as Female	8
Gay	Male at birth	Identify as Transgender	7
Gay	Male at birth	Identify as Female	7
Gay	Male at birth	Identify as Male	6
"Other" (not specified)	Male at birth	Identify as Transgender	5
Bisexual	Male at birth	Identify as Androgynous	3
Gay	Female at birth	Identify as Male	2
Gay	Male at birth	Identify as "Questioning"	2
Asexual	Male at birth	Identify as Female	2
Bisexual	Female at birth	Identify as Male	2
Lesbian	Male at birth	Identify as Transgender	2
"Other" (not specified)	Female at birth	Identify as Male	2
Bisexual	Female at birth	Identify as Transgender	1
Straight/Heterosexual	Male at birth	Identify as Transgender	1
Gay	Female at birth	Identify as Transgender	1
"Other" (not specified)	Female at birth	Identify as Transgender	1
Gay	Male at birth	Identify as Androgynous	1
Straight/Heterosexual	Intersexed Assigned Male at birth	Identify as Female	1
Bisexual	Intersexed Assigned Male at birth	Identify as Androgynous	1
Straight/Heterosexual	Female at birth	Identify as "Questioning"	1
Straight/Heterosexual	Male at birth	Identify as Male	1
"Other" (not specified)	Male at birth	Identify as "Questioning"	1
<b>TOTAL</b>			<b>135</b>

Of the 21 respondents who were biologically assigned “female” at birth, 71.4% identified as “pre-operative” (15 respondents), 19% identified as “post-operative” (four respondents), and 9.5% identified as a “drag king” (two respondents).

Of the two respondents who were “intersexed assigned male” at birth, one respondent identified as “pre-operative,” while one respondent identified as “non-operative.”

## SEXUAL ORIENTATION

(see also, “Sexual Behavior of Transgender Respondents”)

The notion of one’s sexual orientation becomes a complicated construct when conducting social research within the transgender community. It is difficult to account for the tremendous variation among the identities within the transgen-

der community. For many, sexual orientation is not a “transgender-friendly” question, since sexual orientation implies expectations about one’s genitals — either one’s own genitals or the genitals of one’s sexual partners. Heterosexuals are expected to have opposite-genital sexual partners while gay men and lesbians are expected to have same-genital sexual partners. Sexual orientation allows for little variation regarding genitals, therefore usage of the term is less meaningful with transgender persons.

In many ways, sexual orientation assumes the traditional labels of gender identity. Here, there is little to account for states of flux regarding differences in gender at birth versus current gender identification or in regarding circumstances where surgical changes to the genitals have occurred. For instance, there are respondents in this study whose gender at birth was male, they identify as female, and their sexual partners are male. Some of these respondents reported that their sexual orientation is heterosexual, but this would *not* be the view of mainstream society. Other examples involve respondents who may have already had some sexual reconstructive surgery, yet are planning more. One respondent’s assigned gender at birth was male, yet the respondent is now questioning their own gender identity. This respondent has already had top reconstructive surgery and is considering having more. He listed his sexual orientation as “other.”

When developing this needs assessment questionnaire there was discussion as to whether the item about sexual orientation should be included. It was agreed that questions about sexual orientation should be included, but additional inquiries about the gender of the respondent’s sexual partners would be added.

When asked about their sexual orientation, 135 respondents gave the following answers: “heterosexual/straight” (44.4%, 60 respondents), “gay” (19.3%, 26 respondents), “lesbian” (7.4%, 10 respondents), “bisexual,” (20.7%, 28 respondents), “asexual,” (1.5%, two respondents), and “other” (6.7%, nine respondents). One respondent did not give information on this item. Table 8 shows the relationship between sexual orientation, gender at birth, and current gender identification.

## **“OPENNESS” AS A TRANSGENDER PERSON**

**F**or lesbians, gays, and bisexuals (LGBs), being open about one’s identity is often referred to as being “out.” Telling

others about this identity is called “coming out” to others. To be “out” as an LGB often refers to a continuum of “outness,” frequently beginning with an admission to oneself that one is lesbian, gay, or bisexual.

There may be some similarities between “coming out” as transgender and “coming out” as LGB, but there are some very strong differences as well. The similarities include the notion that one, in coming out, comes to terms with one’s own self-identity. This self-identity involves a process whereby one owns and integrates a revised sense of self as a sexual minority or gender minority and, in many cases, no longer hides this minority status. There are also similarities regarding issues of conformity, whereby the person who “comes out” no longer feels intense pressure to fit in to mainstream society’s generic standards of identity, sexuality, and related social behaviors (Finnegan & McNally 2002).

“Outness” is unique to the LGB community, and this admission may take many years to occur as LGB persons come out at different ages. Yet “outness” usually refers to sexual orientation, one’s emotional, romantic, and physical attraction to another person. Sexual orientation is often descriptive of biological gender, since the labels “heterosexual, gay/lesbian, or bisexual” refer to the gender of the sexual partner. For transgender persons, “outness” is not applicable, because the defining characteristics of transgender persons are not dependent on the sexual partner. Instead “openness” about one’s true gender identify is most important. This concept has different meanings for different people (Berger 1995). For transgender persons, “openness” rather than “outness” is the issue.

Yet there are some parallels between “outness” and “openness.” LGB individuals often begin “coming out” to a few people with whom they feel close, comfortable, or safe. For some, these few people may be family members; for others, it may be close friends, a co-worker, trusted neighbor, or special healthcare provider. This inner circle of people with whom LGB persons disclose varies among individuals and is usually based on personal reasons. Results of a local needs assessment of LGB seniors in San Diego County showed that 55% of the sample of 302 seniors had not “come out” before age 40. In this same study, 10.6% of these seniors never came “out.” (Zians 2004).

One's level of "outness" for social research purposes is usually based on the extent that one is "out" to most individuals in one's life. The continuum of "outness" refers to whether or not the person is only "out" to a small group of trusted friends or family, or whether he or she is "out" and openly living as a gay, lesbian, or bisexual person in society. Those most "out" are out to family members, friends, acquaintances, co-workers, neighbors, and healthcare providers. Similarly, "openness" in transgender persons can be measured by asking questions about the extent to which respondents are "open" about their birth gender identity to others: family, friends, co-workers, neighbors, and healthcare providers.

### THE "PASSING PRIVILEGE" AND "OPENNESS"

Many transgender persons have the ability, with the assistance of hormonal and surgical interventions, to "pass" as their identified gender, without others knowing. This "passing" as their identified or "true" gender has become known as a "passing privilege." Yet many are not as successful at attempting to "pass," and the discrepancy between their birth gender and identified gender is more obvious. For some, one's overall physical morphology is such that "passing" without notice would never be possible. For others, medical procedures are too expensive and too painful for "passing" to be an option.

There is some political disagreement about the whole notion of a "passing privilege." "Passing" is to go *unnoticed* as a transgender person. Emerging communities usually do not make progress regarding civil rights and social acceptance by attempting to be invisible. Also, there is an inequality inherent in "passing" given that many transgender persons may never have this option. For this reason some transgender activists have encouraged transgender persons to "come out" (Feinberg 1998). They purport that oppression comes from inflexible social norms. Attempting to "pass" is an attempt to fit into these narrow social norms. In contrast, "coming out" affirms one's identity as a transgender person and adds to community building. Transgender activists suggest that the "coming out" process may lead to decreased shame, isolation and secrecy (Carroll et al. 2002, Feinberg 1998). For some, to attain a

"passing privilege" may be at cross-purposes with "openness".

Survey participants were asked to respond to the following statement: "As a transgender person, I have attained a "passing privilege" (Figure 10). Results from the 130 who responded to this survey item were the following: "strongly agree"(33.1%, 43 respondents), "slightly agree" (17.7%, 23 respondents), "neutral" (21.5%, 28 respondents), "slightly disagree"(10%, 13 respondents), and "strongly disagree" (17.7%, 23 respondents).

An analysis was conducted to determine whether attaining a "passing privilege" predicted outcomes on several other variables. Results showed there was a relationship between attaining a "passing privilege" and having good social support, such that higher ratings of attaining a "passing privilege" predicted high scores on the social support composite measures ( $r = .29$ ,  $p = .001$ ). Apparently attaining a "passing privilege" is related to transgender person's feelings that their friends care about them very much, not feeling lonely and isolated, and expecting good social relationships in the future.

Results also showed that attaining a "passing privilege" was related to life satisfaction. Higher ratings of attaining a "passing privilege" predicted higher scores on the composite measure for life satisfaction ( $r = .20$ ,  $p = .02$ ).

Also, there appears to be a relationship between attaining a "passing privilege" and "openness" about one's transgender identity such that reporting one had attained a "passing privilege" was related to lower scores on the "openness" composite measure on the survey ( $r = .95$ ,  $p < .001$ ). This is an interesting finding and potentially controversial since the civil rights movement for transgender persons relies on more "openness" about one's transgender identity. Those attaining a "passing privilege" who reported less "openness" may not necessarily feel that it is important to be open about their transgender identity. In other words, these individuals are comfortable not being "open" and they perhaps enjoy and appreciate their ability to blend easily with mainstream groups. Other transgender leaders feel that a lack of "openness" may hinder progress in civil rights.

One additional analysis should be noted. There was no relationship between attaining a "passing privilege" and composite scores on measures of good mental health.

Figure 10. "As a Transgender Person, I Have Attained a Passing Privilege." (n = 130)

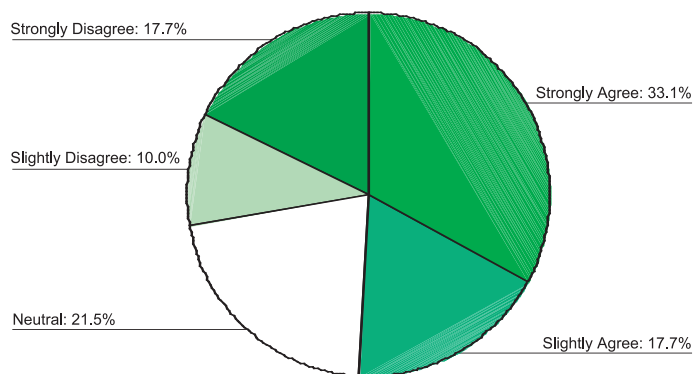


Figure 11. When Were You "Open" About Being A Transgender Person? (n = 133)

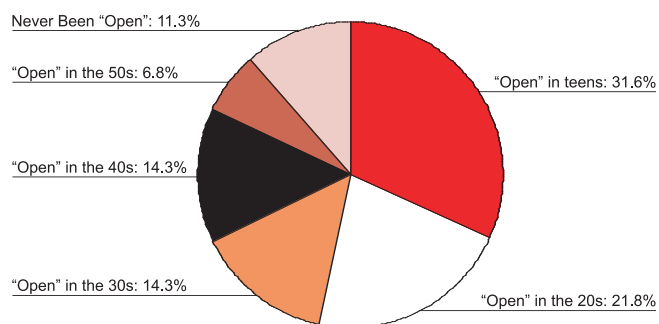
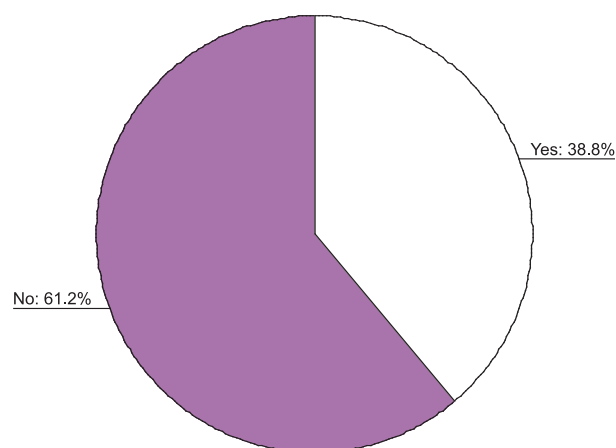


Figure 12. Have You Ever Been Legally Married? (n = 129)



## AGE OF "OPENNESS"

Survey participants were asked to recall the age they became "open" about their gender identity. Response items were listed by decade, e.g., teens, 20s, 30s, etc. (Figure 11). Of the 133 respondents who reported information on age of "openness," 32.4% had not been open about their gender identity by age 39 (43 respondents), and 11.3% reported they have never been "open" about their gender identity (15 respondents). A majority of the respondents, 53.4%, had been "open" about their gender identity by age 29 (71 respondents), and 31.6% had been "open" about their gender identity while in their teens (42 respondents).

## MARRIAGE, DIVORCE, AND CHILDREN

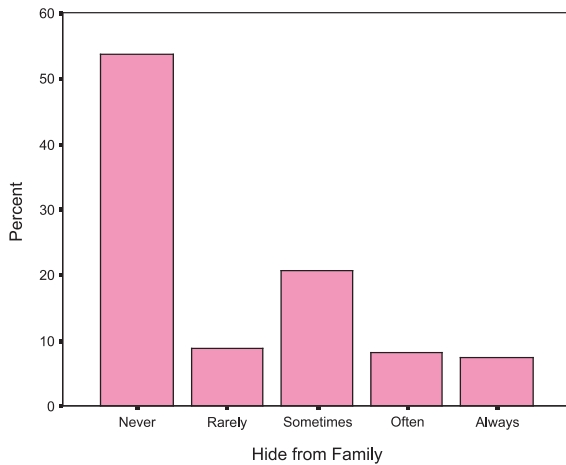
Since there is very little empirical research on the biological, psychological, and developmental processes of transgender persons, little objective information is known about their development throughout life stages from childhood into adulthood and late adulthood. We know that in many cases transgender persons attempt to conform to mainstream society and to meet some expectations of their biologically assigned gender and gender roles. Others may struggle developmentally in different ways and are able to more successfully thwart issues of conformity. Many choose to marry and have children. For some, these life choices do not conflict with issues of gender identity; for others, they do.

Transgender respondents were asked to report whether they had ever been legally married. They were also asked whether the marriage was heterosexual, the number of years they were married, whether they were still married, and whether gender issues contributed to the end of the marriage.

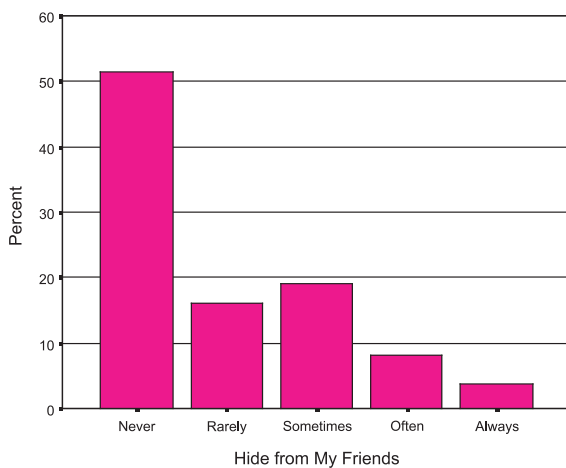
Of the 129 transgender individuals who responded to these survey items, 38.8% had been legally married (50 respondents) (Figure 12). All except four of these marriages were heterosexual (92%). The duration of these marriages ranged from two years to 30 years, with the average marriage lasting 12.7 years.

Only 44% of the respondents who reported having been legally married completed the survey questions concerning whether they were still married and whether gender issues contributed to the end of the marriage (22 of the 50 respondents). Eight respondents reported that their marriages had ended in

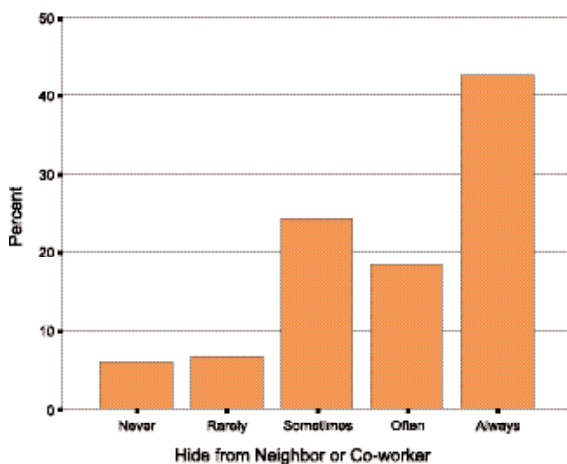
**Figure 13a. "I Attempt to Hide Being Transgender From Members of My Family." (n = 134)**



**Figure 13b. "I Attempt to Hide Being Transgender From My Friends." (n = 134)**



**Figure 13c. "I Attempt to Hide Being Transgender From Neighbors, and Co-workers." (n = 134)**



divorce and seven respondents reported that gender issues had contributed to the end of the marriage. Of the 22 respondents who answered these questions, 12 reported that they were still legally married, and all respondents reported their marriages as heterosexual.

Respondents were also asked if they had children. Of the 128 respondents who completed this survey item, 25.8% reported having children (33 respondents). The number of children ranged from one to four: one child (11 respondents), two children (12 respondents), three children (seven respondents), and four children (two respondents). The ages of the oldest child ranged from 7 to 44 and the ages of the youngest child ranged from 5 to 40. The average age of the respondents' oldest child was 23.3 years and the average age of the respondents' youngest child was 17.6 years.

### **"OPENNESS" WITH FAMILY, FRIENDS, CO-WORKERS, AND NEIGHBORS**

Survey items related to openness with family, friends, co-workers, and neighbors addressed whether or not respondents "hid" their gender identity. Using items derived from Burdon's Openness Scale (modified) as cited in Davis (1998), responses were measured using a 5-point Likert scale: "never," "rarely," "sometimes," "often," and "always."

Of the 134 respondents who completed needs assessment items related to "openness" with family members, the majority, 63.5%, reported they either "rarely" or "never" hide their gender identity (85 respondents) (Figure 13a). In contrast, 15.7% of the respondents reported that they "always" or "often" hide their gender identity from family members (21 respondents), while 20.9% "sometimes" hide their gender identity (28 respondents). Within the respondent sample, 5.8% reported that they had at some time experienced housing problems or homelessness as a result of being estranged from their families due to issues of gender identity (eight respondents).

Other survey items inquired whether or not respondents believed that their families held them in "high regard" and whether they believed they could rely on their families. It should be noted that 79.1% of the respondents reported having parents who were still living (106 respondents).

Only slightly more than half of the respondent believed

that their families held them in “high regard” (76 respondents), while 29.1% did not believe that their families held them in “high regard” (35 respondents). Another 17.2% were “neutral” with regard to whether their families held them in “high regard.”

When asked whether they thought that they could rely on their families, 27.6% of the respondents reported that they could not (37 respondents) (see also section, “Mental Health Issues of Transgender Respondents/Life Satisfaction/Social Support”).

The results related to hiding gender identity from friends were very similar to those found for hiding gender identity from family members. Of the 134 respondents who completed survey items about “openness” with friends, the majority, 68.7%, said they either “rarely” or “never” hide their gender identity (92 respondents) (Figure 13b), while 11.9% “always” or “often” hide their gender identity from friends (16 respondents), and 19.4% “sometimes” hide their gender identity (26 respondents). The results indicate that transgender persons hide their gender identity from heterosexual friends slightly more frequently than they do from non-heterosexual friends. Overall, 75.4% of all respondents believed that they had friends who cared about them very much (101 respondents).

Of the 134 respondents who completed survey items about “openness” to heterosexual friends, only 58.2% either “rarely” or “never” hide their gender identity from heterosexual friends (68 respondents), 20.9% either “always” or “often” hide their gender identity from heterosexual friends (28 respondents), and 20.9% “sometimes” hide their gender identity from heterosexual friends (28 respondents).

Questions concerning “openness” with co-workers and neighbors showed the greatest contrast in terms of transgender persons most often attempting to hide their gender identity. As discussed in various literature on transgender persons, they experience enormous difficulties related to stigma, prejudice, and discrimination in the workplace and in the communities where they live. Of the 134 respondents who completed items about hiding gender identity with co-workers and neighbors, the majority (62.4%) either “always” or “often” hides gender identity from co-workers and neighbors (73 respondents) (Figure 13c). Another 24.8% “sometimes” hides gender identity from co-workers and neighbors (33 respondents),

and only 12.8% of the respondents either “never” or “rarely” hides gender identity from co-workers and neighbors (17 respondents). Interestingly, when comparing the information presented in figures 13a and 13b with Figure 13c, the graphs approximate reverse information, showing that the percentage of those who “never” or “rarely” hide their gender identity from family and friends is similar to the percentage of those who “always” or “often” hide their gender identity from co-workers and neighbors. The bar graphs demonstrate that almost as many respondents who did not hide their gender identity from family and friends did hide their gender identity from co-workers and neighbors.

### **“OPENNESS” WITH MEDICAL CARE PROVIDERS (see also, “Transgender Persons as Healthcare Consumers — Patients and Clients”)**

Leaders in the transgender community are becoming more and more concerned about the relationship between the professional healthcare community and transgender clients. Few healthcare professionals have received training in cultural sensitivity regarding transgender clients. Also, few healthcare providers have adequate training in sexology or gender identity.

Some transgender persons can overtly see the discomfort the healthcare provider experiences in a face-to-face meeting with them. Many endure discrimination and feelings of rejection. At best, a typical experience for a transgender client seen for the first time in a health provider’s office involves the transgender client serving as “learning fodder” for the untrained medical provider (Lev 2002). Many transgender clients are uncomfortable with this experience and therefore avoid it by hiding their gender identity issues. Many transgender clients dress conventionally or according to their biologically assigned gender to ensure their gender issues are not disclosed.

Research literature shows numerous examples of LGB clients remaining “closeted” to healthcare providers about their sexual orientation, and it is believed that fewer than half of all LGBT adults disclose their sexual orientation to medical professionals (Witeck-Combs Communications 2002). Recent studies indicate there may be good reason for this. According to Cahill et al. (2000), the American Association of Physicians

for Human Rights conducted a survey in 1994 that showed 67% of the practitioners surveyed knew of incidences where LGBT patients had received substandard care or were denied care based on sexual orientation. Additionally, a 1991 survey conducted by the American Medical Association reported that a substantial number of general practitioners and internists felt “nervous” with LGBT patients and that 35% of the sample believed homosexuality threatened basic social institutions (Always Your Choice 2003). Discrimination related to sexual orientation is likely to be exacerbated when issues of gender identity are involved.

When asked whether they discuss being transgender with their healthcare provider, 133 survey participants responded. Responses were rated on a 5-point Likert scale ranging from “never” to “always,” and indicated that approximately one-fourth of the sample either “never” or “rarely” shared information about their gender identity with healthcare providers.

Figure 13d, survey participants’ responses regarding disclosure of being transgender to healthcare providers, were as follows: 19.5% “never” disclose (26 respondents), 3.8% “rarely” disclose (five respondents), 17.3% “sometimes” disclose (23 respondents), 16.5% “often” disclose (22 respondents), and 42.9% “always” disclose (57 respondents).

When asked whether any of their healthcare providers was an LGBT person (at least one healthcare provider), only 30.6% of the 134 respondents who answered this question reported “yes” (41 respondents). A recent study of 302 LGBT seniors in San Diego County showed similar results such that

only 30.1% reported having at least one healthcare provider who was an LGBT person (Zians 2004) (see also: Trust and Other Issues Concerning Healthcare Providers/ Predictors of Healthcare Satisfaction, Confidence, and Optimal Care).

## SAFETY ISSUES RELATED TO “OPENNESS”

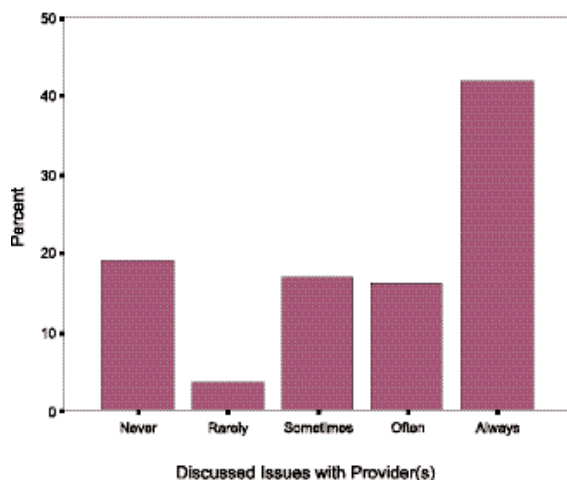
Fear of assault is often on the mind of a transgender person. Frequent crimes that may befall a transgender person include harassment, discrimination, verbal abuse, physical assault, and sexual assault. Many transgender persons do not feel safe in their homes. For some, the inability to “pass” without notice as a member of one’s identified gender may bring unwanted attention that could lead to violence (Dean et al. 2000).

Survey participants were asked whether or not they felt safe where they live. Of the 131 respondents who completed this question, 13% reported they did not feel safe (17 respondents) (Figure 14). The following quotes indicate their feelings of insecurity related to being a transgender person in their neighborhood, stating reasons why they do not feel safe:

- *“I cannot be open about TG issues where I live, nor dress how I wish.”*
- *“I must spend a lot of time applying makeup before I go out for safety reasons.”*
- *“My neighbors know I am a boy and when I leave for work I come out dressed as a girl and they are always staring at me.”*
- *“It is not safe to be out as an (m to f) transgender person in Oceanside.”*
- *“I feel repressed. Not necessarily physically unsafe.”*
- *“I keep myself safe by not putting my business in the streets.”*

Those who reported they did not feel safe where they live were more likely to have a lower annual income ( $t = 3.70$ ,  $df = 45.4$ ,  $p = .001$  [unequal variance not assumed]). Respondents who did not feel safe where they live were also more likely to have less social support in their lives, since those who did not feel safe at home scored lower on the social support composite measure ( $t = 2.50$ ,  $df = 18.2$ ,  $p = .02$  [equal variances not assumed]). In addition, there was a relationship between feeling

**Figure 13d. “I Have Discussed Issues of Being Transgender With Healthcare Provider(s).” (n = 133)**



safe where one lives and life satisfaction such that feeling unsafe at home predicted low scores on the life satisfaction measure ( $r = -.18, p = .04$ ).

Respondents were asked whether they needed services regarding hate crime violence. Table 9 shows that 8.1% reported they “needed but had no access to these services” (11 respondents).

An interesting relationship was found regarding hate crime violence and a question about social isolation, “...drawing away from people.” Hate crime violence was related to “drawing away from people,” such that reporting a need for Hate Crime Violence services also related to reporting that they are drawing away from people more ( $r = .3, p = .5$ ). One may interpret this as an issue of trust. Individuals who have experienced hate crime violence may be highly ambivalent in their social interactions resulting in avoidance and withdrawal behaviors.

**Table 9. Need for Hate Crime Violence Services (N = 136)**

Need and have access	4
Don't Need	111
Need and No Access	11
Can't Afford	2
Need More Information	9
Services are Not LGBT Friendly	2
Services are Unavailable to Me	2

## TRANSGENDER PERSONS AND ISSUES SURROUNDING MEDICAL SURGERY, BODY MODIFICATION PROCEDURES

During a meeting attended by local transgender representatives who were assisting with the final edit of this needs assessment report, a question was raised about the term *sex reassignment surgery*, referred to as *SRS*. This is the term used to describe the surgical procedures allowing for cosmetic changes to genital organs and secondary sexual characteristics for the purpose of altering one’s physical body to better match one’s identified gender. A group member suggested the term be replaced with another term — *sex realignment surgery*. According to community representatives, using the word *realignment* better describes what is really happening; the group agreed that no one is changing one’s gender via surgery;

instead they are “...getting their body to agree with their true self.” Keeping with standard language used in the current literature about transgender persons, the local transgender representatives agreed to the term *sexual reassignment surgery* for use in this report, yet the representatives unanimously stated that they hoped the term *sexual realignment surgery* would someday be preferred.

### “DO YOU EVER PLAN TO HAVE SEX REASSIGNMENT SURGERY (SRS)?”

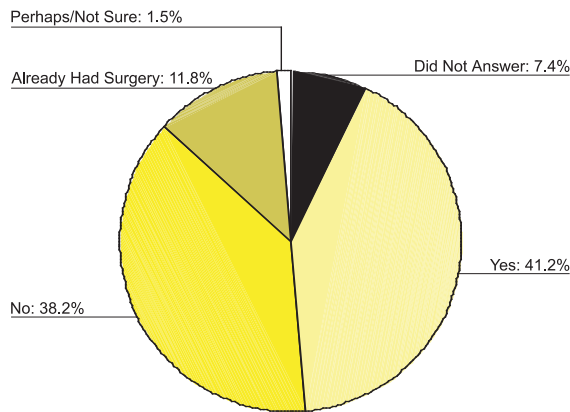
In order for a transgender person to obtain sex reassignment surgery or SRS, they must have two letters of recommendation from qualified mental health professionals. They also need to successfully live for one year as the identified gender (see also, “The Harry Benjamin International Gender Dysphoria Association”). The profile of the transsexual approved for surgery includes: a) a childhood history of wishing one was physically the opposite gender; b) gender dysphoria in childhood; c) gender dysphoria in adolescence and adulthood; d) discomfort (often disgust) with one’s secondary sexual characteristics; e) eagerness to surgically remove their penis, or breast/vagina; and f) pervasive fantasizing that their physical body matches their identified gender (Bullough, Bullough & Elias, 1997).

There is the belief by some that, with increased social acceptance and the development of a more tolerant, empathic climate, more transgender persons may be comfortable with their gender situation without opting for sex reassignment surgery. While in the U.S., and North America and Europe, most sex reassignment surgery is male-to-female, in China female-to-male surgery is most prevalent (Bullough et al. 1997).

Respondents were asked if they were planning to have SRS. Responses included: “yes” (41.2%, 56 respondents), “no” (38.2%, 52 respondents), “already had surgery” (11.8%, 16 respondents), and “perhaps, not sure” (1.5%, 2 respondents) (no response to this question was given by 10 respondents) (Figure 15).

Those 56 respondents who reported they planned to have SRS were asked when they planned to have this surgery. These respondents reported the following timelines: “within 6 months” (4.4%, 6 respondents), “within one year” (2.2%,

Figure 15. “Are You Planning to Have Sex Reassignment Surgery?” (n = 126)



3 respondents), “one to three years” (16.2%, 22 respondents), and “more than three years” (17.6%, 24 respondents) (one respondent reported they did not know when).

Barriers to SRS were reported by 54.4% of all respondents (74 respondents). For medical reasons, certain health problems can exclude someone from receiving SRS. Health issues that were listed as barriers to SRS by local respondents include: “obesity” (nine respondents), “high blood pressure” (11 respondents), “heart problems” (five respondents), “HIV” (11 respondents), “mental health problems” (nine respondents), “diabetes” (two respondents), and “congenital birth defect” (one respondent).

Other barriers reported included: financial, concerns about qualification, medical issues that could interfere, overwhelming social complications related to SRS, and unfamiliarity with SRS. Many respondents wrote comments regarding the financial barrier of SRS, given that the cost of surgery is exorbitant — “tens of thousands of dollars.” Many transgender persons in the U.S. travel to other nations such as Thailand where SRS surgery is more affordable (Conway, 2005). Also, the lack of health insurance coverage for the unique needs of transgender persons was listed consistently as a barrier to SRS.

## OTHER IMPLICATIONS TO SEX REASSIGNMENT SURGERY (SRS)

Analyses were run to see whether having already received sex reassignment surgery predicted scores on several measures: good mental health, good social support, “openness,” having attained a “passing privilege,” and life satisfaction.

Results showed no significant relationships among these variables. Although no significant relationships were found, it may be important to note that a potential relationship between two groups were observed on the composite measure of life satisfaction: 1) respondents who already had sexual reconstruction surgery and 2) respondents who hoped to someday have SRS surgery. Though this relationship was not significant, it was approaching significance. With a larger sample of respondents this relationship may have been found (“already had SRS” mean = 18.4, “not yet had SRS” mean = 16.0;  $F [1,69] = 2.8$ ,  $p = .09$ ). Here the partial Eta squared was .039 demonstrating a medium effect size.

Additionally, when the above analysis was run again, and combining respondents who “already had SRS” with those respondents who reported they “did not want” SRS, results showed a greater approach toward significance (“already had SRS or don’t want SRS” mean = 17.6, “not yet had SRS” mean = 16.0;  $F [1,121] = 3.7$ ,  $p = .056$ ). Here the partial Eta squared was .03 demonstrating a medium effect size.

Had these last two analyses demonstrated statistical significance, one could conclude that those respondents who want SRS yet have not yet been able to have SRS score lower on the life satisfaction composite measure than respondents who already had SRS and respondents who do not want SRS. Again, since significance was not found with this sample, this conclusion cannot be made. Perhaps some time in the future, with a larger sample size, this analysis can be repeated.

## CHARACTERISTICS OF TRANSGENDER RESPONDENTS: CURRENT ANATOMY, BODY MODIFICATION AND HORMONE THERAPY

Respondents were asked to report descriptions of their current anatomy related to body augmentation. Of the 17 respondents who reported having had SRS surgery, the following descriptions were listed: “had complete female to male (f to m) top surgery” (7 respondents), “had breast with surgical implants” (14 respondents), “had a surgically constructed vagina” (13 respondents), “had a surgically constructed clitoris” (10 respondents), “had a surgically constructed labia” (12 respondents) and “had facial cosmetic surgery” (10 respondents). No other surgical procedures were reported.

Not all transgender persons who opt to make changes to their physical anatomy choose surgical procedures. Body augmentation can be attained through other means. Another method of body modification related to gender is through hormone administration.

Respondents were asked whether they had a history of taking hormones. Approximately 70.5% of all respondents reported some history of participating in hormone therapy (96 respondents). More than half (55.1%) of all respondents reported current use of hormone therapy (75 respondents), 2.9% reported hormone therapy in the past but have no future plans to resume treatment (four respondents), 9.6% reported hormone therapy in the past with future plans to resume treatment (13 respondents), and 2.9% reported hormone therapy in the past while unsure whether they will resume therapy. Only 6.6% reported they never participated in hormone therapy and have no future plans to begin therapy (nine respondents). Five respondents did not complete questions regarding hormone therapy. Of the 96 respondents who reported having hormone therapy, 29.2% reported they were not under the care of a licensed physician.

Some transgender persons use silicone injections to augment feminine features. This is generally done without medical supervision and sometimes by peers within the transgender community. These events are called “pumping parties,” where members of the transgender community gather to have their bodies augmented. With limited access to appropriate medical and cosmetic care, “pumping parties” are extremely popular and have become legend in the transgender community. These events are usually advertised by “word of mouth” and remain highly anticipated by attendees. As tradition, attendees receive silicon (often industrial grade silicon) that is directly injected into the body to enhance breast, buttocks, and lips. This is an extremely dangerous procedure that may cause serious or even fatal health complications.

On June 21, 2005, a “pumping party” ended tragically for two local San Diego transgender residents. Five women attended a pumping party held in University Heights. Soon after the procedure, two of the women were rushed to the hospital due to severe breathing problems, and they were immediately placed on life support. On July 11, 2005, one of these women died from complications related to this unsupervised, illegal, silicone procedure, the other continues to have some health problems (Ralston, 2005).

## **THE INTERNET AS A KEY SOURCE OF INFORMATION**

**I**t appears that the internet has become a much relied upon source of information to local transgender persons, for many

transgender affiliations included internet-related groups. This is particularly important regarding information about SRS, hormone therapy or other treatments. Results of the needs assessment survey showed that one-half of all respondents reported receiving transgender-related information via the internet (68 respondents). When asked about service needs related to the internet, 14% of all respondents reported that they “needed, but had no access to the internet” (19 respondents). When asked about particular barriers to receiving internet services, 8.8% percent of the respondents reported they “could not afford” the internet (12 respondents), and 8.2% reported they “needed more information” related to internet services (11 respondents).

## **TRANSGENDER PERSONS AS HEALTHCARE CONSUMERS — PATIENTS AND CLIENTS**

### **TRUST AND OTHER ISSUES CONCERNING HEALTHCARE PROVIDERS/PREDICTORS OF HEALTHCARE SATISFACTION, CONFIDENCE, AND OPTIMAL CARE**

**F**ew healthcare providers have been properly trained to work with transgender clients. According to Lev (2004), only a handful of sexologists, medical doctors, psychotherapists, social workers, and other clinicians have received adequate training to deal with transgender patients in a culturally satisfactory manner.

Healthcare professions must be educated about the special healthcare needs of the transgender community before transgender persons can ever receive culturally appropriate services. There are, however, many challenges to this task. First, the healthcare professions need to reevaluate many of their assumptions about gender, sexuality, and sexual orientation. Biologically determined gender remains an affirmed assumption in mainstream culture, and it appears that this definition of gender is instilled within the healthcare profession (Carroll et al. 2002).

Second, the healthcare profession continues to be fixed on heterosexual assumptions – the presumption that all individuals are heterosexual, that they are sexually and romantically

attracted to members of the opposite sex, and that all people enjoy marriage rights and the ability to make medical decisions on behalf of their loved ones. Heterosexual assumption affects the entire LGBT community, not simply transgender persons. It creates barriers to quality healthcare as LGBT patients are dismissed, invalidated, and made invisible (Butler 2002, Healy, 2002). This can also lead to mismatches regarding best health-care practices, and poor healthcare decisions for LGBT individuals (McVinney 1998, Meyer 1990).

Healthcare services that are not culturally appropriate to transgender persons can lead to increased distrust between client and provider and foster feelings of insensitivity. An impasse in a relationship between healthcare provider and patients can inflict psychological pain and prevent someone from attaining much-needed healthcare services. Since curiosity and good intentions do not create good healthcare, many transgender persons have had mixed experiences with healthcare providers.

Survey participants were asked to respond to the following survey item: “My doctors or healthcare providers are competent regarding transgender issues.” Using a 5-point Likert scale ranging from “strongly agree” to “strongly disagree,” results showed that only 11.1% of the 126 respondents completing this survey item reported that they “strongly agreed” (14 respondents).

As previously stated, many transgender respondents were hesitant to disclose that they were transgender to healthcare providers: 19.5% “never” disclose (26 respondents), 3.8% “rarely” disclose (five respondents), 17.3% “sometimes” disclose (23 respondents), 16.5% “often” disclose (22 respondents), and 42.9% “always” disclose (57 respondents).

Interestingly, good communication and a rapport that inspires trust and care between transgender clients and their healthcare provider are highly related to several variables that predict client satisfaction, treatment adherence, and overall positive attitudes toward healthcare services.

An analysis of survey respondents from those that *chose to* disclose their transgender status with healthcare providers showed the following relationships.

Respondents who disclosed their transgender status to healthcare providers also:

- Believed that their healthcare providers “knew them well, and made decisions in my best interest” ( $r = .27, p = .002$ )

- Believed that “most of my needs as a transgender person are met by my healthcare provider” ( $r = .23, p = .04$ )
- Believed that “my doctors and providers know that I am a transgender person and they use this information to help me with medical issues” ( $r = .38, p < .001$ )
- Believed that “I trust my healthcare provider and I follow through with their advice” ( $r = .18, p = .04$ )

There were also results that demonstrate problems that may arise for those transgender clients who *do not* disclose their transgender status to healthcare providers. Results show that choosing *not* to disclose one’s transgender status was related to the following:

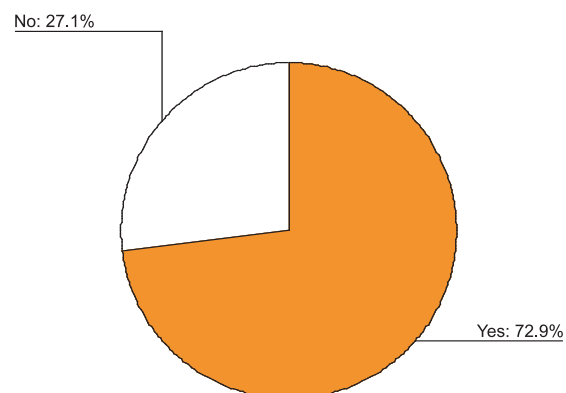
- “I avoid going to the doctor due to negative experiences of hostility, discrimination and prejudice” ( $r = -.21, p = .02$ )
- The *lack of a* belief that their healthcare providers “were considerate of their needs” ( $r = -.18, p = .04$ )

## HEALTH INSURANCE/ACCESS TO MEDICAL CARE

Survey participants were asked questions regarding health insurance and their type of health insurance plans. Of the 133 respondents who completed these items, 27.1% reported that they had no health insurance (36 respondents) (Figure 16).

Of the 95 respondents who reported having health insurance, most had private HMO insurance (35.8%, 34 respondents) or private insurance (15.8%, 15 respondents); 12.6% were on Medi-Cal or Medicaid (12 respondents); 9.5% were on Medicare (nine respondents); 6.3% received Ryan White benefits (six respondents); 3.2% were on government disability,

Figure 16. “Do You Have Health Insurance?” (n = 133)



SSI, or SSA (three respondents); 1.1% received civil service benefits (one respondent); and 3.2% did not specify their type of health insurance (three respondents). Approximately 12.6% reported they were veterans and had military medical insurance (12 respondents).

Survey participants were asked how often they saw their medical doctor. Of the 136 respondents who completed survey items about their medical appointments, 42.6% reported seeing their doctor “at least two times per year” (58 respondents), 29.4% reported seeing their doctor “one time per year” (40 respondents), 13.2% reported seeing their doctor “every two to three years” (18 respondents), and 14.7% reported they had not seen their doctor in “three years or more” (20 respondents).

Regarding the frequency of dental visits, 134 respondents reported the following: 38.1% saw their dentist every six months (51 respondents), 25.4% saw their dentist one time per year (34 respondents), and 36.6% reported they had not seen a dentist in more than one year (49 respondents).

Of the 135 respondents who reported the frequency of visits to their eye doctor, approximately 55% of all respondents reported seeing an eye doctor at least once every two years (74 respondents), while 45.2% had not seen an eye doctor in two or more years (61 respondents).

## MENTAL HEALTH ISSUES OF TRANSGENDER RESPONDENTS

### HISTORY WITH GAYS AND LESBIANS

Though the social climate in the U.S. today shows more social tolerance for the aggregate LGBT community at large, transgender persons, as a group, still remain a highly stigmatized subpopulation within the community. It is within this context that issues of mental health become confounded and highly complicated regarding transgender persons because the mental health profession treats issues of gender identity very differently than it treats issues of sexual orientation.

The LGBT community in the U.S. has already had a rocky history with the mental health profession surrounding the issue of diagnoses. Those individuals who engaged in same-sex behaviors were termed “deviant,” and sexual behavior between

same-sex couples was considered “abnormal” and they were often labeled as “paraphilic,” “fetishistic,” or “deviant.” *The Diagnostic Statistical Manual of Mental Health Disorders (DSM)*, a classification system used as a diagnostic resource guide in psychiatry and psychology, not only diagnosed homosexuality as a mental disorder, but it was further categorized as a personality disorder (Lev 2004).

It was in this context that the mental health profession attempted to cure conflicts related to transgender issues by psychotherapy. From the 1890s until the 1960s, the psychoanalytic approach developed by Freud and his followers dominated clinical practice in Europe and much of the U.S. This clinical approach conceptualized the male cross-dresser as a latent homosexual, and female cross-dressers as victims of a so-called “Electra complex” (women wishing they had a penis). Clinicians working in this manner with transgender clients held a premise that transgender clients possessed a perversion (Bullough et al. 1997).

The work of Evelyn Hooker, in 1957 and again in 1967, provided convincing evidence that demonstrated homosexuality was neither a mental illness nor a personality disorder. Yet even with scientific evidence, it was difficult to persuade the mental health community that homosexuality was not a mental disorder. Sixteen years after Evelyn Hooker’s first publication, and following what many considered a political lobbying effort by the LGBT community and evidence-driven mental health professionals, homosexuality was finally removed from the list of mental disorders and personality disorders in 1973. Only a diagnosis of “ego dystonic homosexuality” remained. This was a diagnosis for someone with same-sex attraction who did not want to be homosexual. In 1986, this was also removed from the DSM.

What has remained in the DSM are two sets of diagnostic labels for individuals with issues about gender and gender identity: 1) Gender Identity Disorder (GID) (children may receive the childhood version of the diagnosis) and 2) Transvestic Fetishism (includes some transvestites, cross-dressers and drag queens).

Though diagnostic labels are still on the books for gender identity issues, one can trace the manner in which gender disorders have been revised in updated versions of the DSM (1987, 1994). Within the explanations of the diagnostic

category of GID in the DSM, the term “transsexualism” was removed as a diagnostic disorder and replaced with the term “gender dysphoria,” used as a descriptive for individuals who experience discomfort with their birth gender identity (Bullough et al. 1997). Additionally, changes in the DSM pertaining to gender issues were also noted by 1994. Regarding the diagnosis of “transvestic fetishism”(desire to cross-dress), descriptive explanations state that cross-dressing is not always pathological (Bullough et al. 1997).

### **A “CATCH TWENTY-TWO” SITUATION: MENTAL HEALTH PROFESSIONALS AS “GATEKEEPERS”**

Gender identity remains a complicated issue. Unlike the history of homosexuality, gender identity remains a disorder listed in the DSM. Since gender identity issues are classified as a mental health disorder, there is an odd “catch twenty-two” involved. If a transgender person wants SRS, they must receive a mental health diagnosis of GID. Without this diagnosis, surgery is deemed inappropriate and unethical. Pathology is implicit in the mental health diagnosis of GID or transvestic fetishism, and the implications of these diagnoses are that gender variation implies abnormality, illness, and a need for a viable cure.

In addition to the role as a diagnostician, the mental health professional has essentially become the “gatekeeper” of all SRS procedures. Individuals who desire sex reassignment surgery may not receive care without a GID diagnosis. This sad conundrum is complicated—the triage process that assesses a transgender person’s appropriateness for treatment simultaneously assigns *pathology* to gender-related difficulties. Many believe this circumstance to be both unfortunate and undeserving (Lev, 2004).

Mental health professionals are also given the task of assessing whether candidates applying for sex reassignment procedures successfully completed all necessary eligibility criteria, such as living full-time as the desired gender for a period of one year prior to surgery. Medical procedures cannot commence without written recommendations by mental health professionals who oversee and document completion of eligibility conditions (see also: Transgender Persons and Issues Surrounding Medical Surgery).

### **THE HARRY BENJAMIN INTERNATIONAL GENDER DYSPHORIA ASSOCIATION**

By the 1960s, the onset of sex reassignment surgery and other non-surgical procedures that enhanced gender appearance created the conditions whereby clinical guidelines were necessary for the unique medical needs of transgender clients. Without any official clinical guidelines, doctors were evaluating their transgender clients for surgical appropriateness. Given the invasiveness of sex reassignment surgery and the mental health implications of physically changing one’s anatomical gender, ethical, clinical and legal issues soon came to the forefront of medical issues specific to transgender persons.

In 1979, the Harry Benjamin International Gender Dysphoria Association developed therapeutic standards of care for transgender persons seeking medical care. These guidelines require that healthcare providers be properly trained and credentialed if working with transgender clients, including transgender children, and include detailed proper clinical counseling procedures (Lev, 2004).

These standards of care also outline necessary criteria and qualifications that should be met before a transgender person can receive medical procedures or surgery that involves gender reassignment. The standards address complications that may arise regarding one’s social support system. These standards of care, which are widely accepted, address issues related to a person’s family of origin, current partners, children, and an extended family such as close friends (Lev, 2004).

### **LOCAL DATA ON TRANSGENDER PERSONS’ MENTAL HEALTH**

Transgender respondents were asked to complete survey items related to mental health issues based on an overall composite scale developed to measure “good mental health.” Respondents were instructed to check items describing health symptoms that applied to them, and they were also asked to give ratings regarding mental health issues. Of the items related to mental health, 13 demonstrated good internal consistency (Cronbach alpha = .91). In addition, a factor analysis was run on these 13 mental health survey items in order to carefully look at the structure of the scale. A single factor (eigenvalue = 6.24) accounted for 48% of the variance. Factor loadings

for the 13 mental health survey items ranged from .58 to .81.

The validity of these 13 survey items was measured against four independent items: 1) “good mental health” was found to be related to “looking back on my life and feeling fairly well satisfied” ( $r = .22, p = .01$ ); 2) “good mental health” was related to “feeling well liked by others” ( $r = .21, p = .02$ ); 3) “good mental health” was related to a belief that “the next 10 years will have some happiness and satisfaction” ( $r = .22, p = .01$ ); and 4) “good mental health” was related to the belief that “most things are as interesting to me as they ever were” ( $r = .22, p = .01$ ).

Perhaps one of the most important survey findings was related to “good mental health and “increased life satisfaction.” “Good mental health” was related to survey items measuring “increased life satisfaction” ( $r = .39, p < .001$ ). A similar finding was found between “good mental health” and “good social support” ( $r = .78, p < .001$ ) (see also: Life Satisfaction/Social Support).

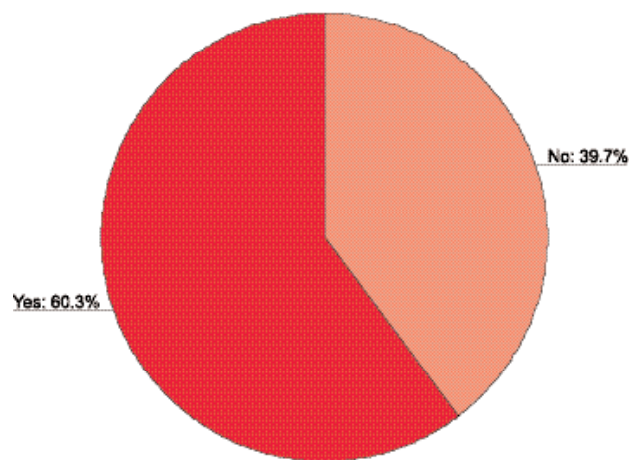
Mental health problems appear to be an issue for many transgender respondents in this sample. A past history of mental health problems was reported by 31.6% of the respondents (43 respondents). As previously stated, a history of substance abuse and addiction problems were reported by 11.8% of the respondents (16 respondents). The 13 item mental health composite scale used to assess “good mental health” ranged in scores from “zero,” the lowest possible score, to “thirteen,” the highest possible score. Fifteen percent of the sample scored either a “zero” or a “one” on this composite measure. Additionally, approximately one-third of the sample received a score of “six” or less on this measure which means they were reporting numerous mental health symptoms (40 respondents).

Overall, mental health issues related to mood such as “depression,” “poor self-esteem,” “nervousness,” “anger problems” and “problems controlling their thoughts” were pervasive among the transgender sample. The majority of all respondents (60.3%) reported they experienced feelings of depression during the past 12 months (82 respondents). When asked about short-term depression versus long-term depression, 60.3% of all 136 respondents reported they experienced a short-term depression during the past 12 months (82 respondents), while 37.5% reported they experienced a long-term depression during the past 12 months (51 respondents) (Figure

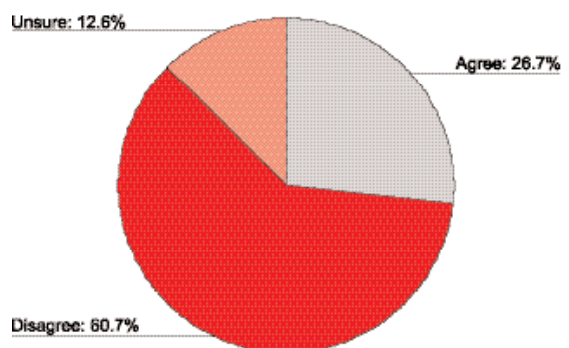
17a). Thirty-nine percent of the respondents reported they had seen a counselor or therapist for depression during the past year (53 respondents). When asked whether they were currently taking psychiatric medications for depression, 22.1% of the respondents reported they were taking medications for depression (30 respondents).

Other survey items captured mental health concerns related to depression. One-fourth of all respondents reported that they felt this was “...the dreariest time of my life” (36 respondents) (Figure 17b). Of the 136 respondents, results showed that 55.1% reported that they felt “sad and depressed” (75 respondents), while 41.9% reported they had “poor self-esteem”

**Figure 17a. Experienced Short-term Depression During the Past 12 Months (n = 136)**



**Figure 17b. “This is the Drearist Time of My Life.” (n = 135)**



(57 respondents), 32.4% reported they experienced “nervousness” (44 respondents), 30.9% reported “anger problems” (42 respondents), and 26.5% reported “problems controlling their thoughts” (36 respondents).

When asked about their need for mental health counseling, 27.9% of the respondents reported they currently “need and have access” to services (38 respondents), while 13.2% reported that they “needed, but had no access” to mental health services (18 respondents), 51.5% reported that they “did not need” mental health services (70 respondents), 9.6% reported they “could not afford these services” (13 respondents), 6.6% reported they “needed more information” about these services (9 respondents), 2.9% reported these “services were not LGBT friendly” (4 respondents), and 2.2% reported that “these services are unavailable to me” (3 respondents). Almost one-fifth of all respondents reported that “they needed, but had no access” to support group services for transgender persons (27 respondents). (Tables 10a and 10b).

**Table 10a. Need for Mental Health Counseling Services (N = 136)**

Need and have access	38
Don't Need	70
Need and No Access	18
Can't Afford	13
Need More Information	9
Services are Not LGBT Friendly	4
Services are Unavailable to Me	3

**Table 10b. Need for a Transgender Support Group (N = 136)**

Need and have access	53
Don't Need	49
Need and No Access	27
Can't Afford	5
Need More Information	23
Services are Not LGBT Friendly	3
Services are Unavailable to Me	5

Interestingly, although results show that respondents face many mental health challenges, survey items that inquire about expectations toward the future reflected much optimism. Respondents were asked to rate their “outlook toward the future during the next five years.” On a five-point scale from “very poor” to “very good,” respondents reported the follow-

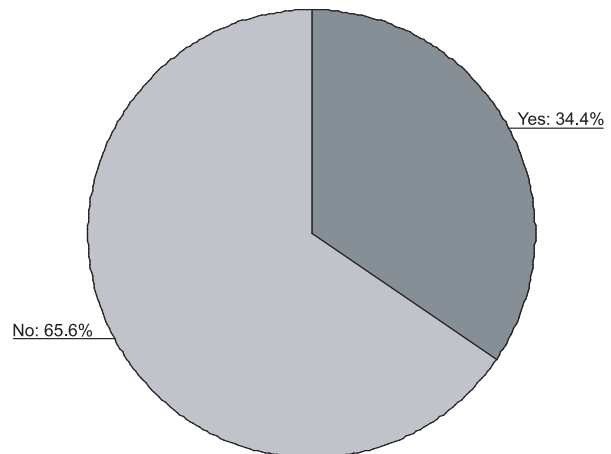
ing: “very good” (52.9%, 72 respondents), “somewhat good” (29.4%, 40 respondents), “fair” (11.8%, 16 respondents), “somewhat poor” (1.5%, 2 respondents), “very poor” (1.5%, 2 respondents).

## SUICIDAL IDEATION

Survey results regarding suicidal ideation were disturbing. Among the transgender respondents, 31.6% reported having suicidal ideation during the past 12 months (43 respondents), and 17.6% reported a suicide attempt sometime during their past (24 respondents) (Figure 17c).

The respondents, who reported suicidal ideation during the past year, were asked whether suicidal ideation was related to transgender issues. Only 61 of the 82 respondents who had reported suicidal ideation responded to this survey item. Of these 61 respondents, 52.5% reported that suicidal ideation was related to transgender issues (32 respondents).

**Figure 17c. Do You Experience Suicidal Ideation? (n = 125)**



## LIFE SATISFACTION/SOCIAL SUPPORT

Transgender respondents were asked a set of survey questions regarding life satisfaction as described by Neugarten, Havinghurst and Tobin (1961) and social support. Results of the transgender survey findings match research results cited in the psychological literature regarding the relationship between increased life satisfaction and “good social support.” High scores on the “life satisfaction” measure were related to high scores on “good social support” ( $r = .34, p < .001$ ).

Also, much research literature demonstrates that having a strong social support system serves as a buffer for many challenges in life, particularly regarding health concerns and mental health problems such as depression (Holahan and Holahan, 1987). The results of the Transgender survey findings also support this research, for as previously stated, survey results showed that there was a strong relationship between “good mental health,” increased life satisfaction, and “good social support” such that high scores in “good mental health” were related to high scores on the life satisfaction measure ( $r = .39, p < .001$ ) and high scores in “good social support” ( $r = .78, p < .001$ ).

Analyses of survey items related to life satisfaction and social support yielded some other interesting findings:

- “Increased Life Satisfaction” scores were related to being more “open” about one’s transgender identity ( $r = .24, p = .005$ )
- “Increased Life Satisfaction” scores were related to “having attained a ‘passing privilege’” ( $r = .23, p = .007$ )
- “Good Social Support” scores were also related to “having attained a ‘passing privilege’” ( $r = .19, p = .03$ )
- “Increased Life Satisfaction” scores were related to being more prepared for employment ( $r = .25, p = .003$ )
- “Good Social Support” scores were also related to being more prepared for employment ( $r = .20, p = .02$ )
- “Increased Life Satisfaction” scores were related to having fewer barriers to education ( $r = .21, p = .01$ )
- “Good Social Support” scores were also related to having fewer barriers to education ( $r = .19, p = .03$ )

## CONNECTION AND AFFILIATION TO LGBT SERVICE PROVIDERS

Transgender respondents were asked a series of questions about their social and community affiliations. First, respondents were asked whether they belonged to any LGBT affiliate groups. Thirty-seven percent reported group affiliations (50 respondents). Included in some of these LGBT group affiliations were: The Center, the Hillcrest Youth Center, the Greater San Diego Business Association (GSDBA), the

Imperial Court, Parents, Families of Lesbians & Gays (P-FLAG), TransFamily, the Rainbow Gender Association, Transpire, PROCABE, the Democratic Club, and Metropolitan Community Church (MCC). Almost one-fourth of all respondents reported that they were affiliated with a place of religious worship, such as the Metropolitan Community Church (MCC) or other religious place in San Diego County (23.7%, 31 respondents).

A survey item inquired about potential service needs for transgender persons provided by LGBT organizations. When asked to rate the ability of transgender persons to rely on LGBT services during the next five years, results were mostly optimistic: “very poor” (2.2%, 3 respondents), “somewhat poor” (6.6%, 9 respondents), “fair” (21.3%, 29 respondents), “somewhat good” (34.6%, 47 respondents), “very good” (33.1%, 45 respondents) (3 respondents gave no response to this item). Similarly, respondents were asked to rate their ability to rely on San Diego’s transgender community for services during the next five years. Responses were as follows: “very poor” (8.1%, 11 respondents), “somewhat poor” (8.1%, 11 respondents), “fair” (21.3%, 29 respondents), “somewhat good” (25.7%, 35 respondents), “very good” (33.1%, 45 respondents), (5 respondents gave no response to this item). Additionally, high ratings in these two areas—reliance on LGBT community for services and reliance on the transgender community for services during the next five years—were related to each other such that a belief one that could rely on LGBT services was also related to the belief that one could rely on the transgender community for services ( $r = .18, p = .05$ ). Yet this correlation is a fairly low one.

Respondents were asked to give their response to the following survey item: “I feel that local LGBT organizations support transgender persons in the community.” Results were the following: “strongly disagree” (5.9%, 8 respondents), “disagree” (11.8%, 16 respondents), “neutral” (28.7%, 39 respondents), “agree” (29.4%, 40 respondents), “strongly agree” (21.3%, 29 respondents) (4 respondents gave no response to this time).

Interestingly, there was a relationship between not providing one’s zip code on the survey and the belief that one could rely on the transgender community for services during the next five years such that ratings of those respondents with missing zip codes were related to higher ratings that one could rely on the

transgender community for services ( $r = .20, p = .02$ ). Earlier it was noted that 25% of all respondents did not provide their zip code, and this was interpreted as a possible trust issue.

## HEALTH CONCERNS

### HEALTH CONDITIONS OF TRANSGENDER RESPONDENTS IN SAN DIEGO COUNTY

Very little is known about the specific health needs of transgender persons with the exception of conditions related to specific medical procedures used to augment the physical morphology of their identified gender such as hormone therapy or sex reassignment surgery. Aside from these specific medical procedures, the health concerns of transgender persons are similar to the health concerns of most Americans.

Table 11 lists medical problems experienced by the transgender respondents of this needs assessment. All 136 survey participants responded to this survey question.

It is possible that transgender persons, like gay and bisexual men, may be at a higher risk for anal carcinoma, and it appears that transgender persons also have a higher incidence of HIV/AIDS and sexually transmitted diseases (STDs) (Dean et al. 2000, Kaiser Permanente 2000) (see also section, “HIV/AIDS and Related Mental Health Issues”). Some transgender persons assigned female at birth may be vulnerable to specific health risks and health concerns that have been reported for lesbians and bisexual women. Some of these risks include certain cancers such as breast, cervical, lung, and colon cancers (Dean et al. 2000, Solarz 1999).

It is also evident that there are mental health needs specific to transgender persons and many would benefit if an array of counseling services were tailored to the transgender community, treating the community as a unique target group. Clearly this would include crisis intervention and suicide prevention services. As the visibility of transgender persons in our communities across American continues to increase, there will likely be more demand for culturally appropriate mental health services within the transgender community (Dean et al. 2000, Hunter & Mallon 1998) (see also section, “Mental Health Issues of Transgender Respondents”).

**TABLE 11. PAST HEALTH PROBLEMS REPORTED BY TRANSGENDER RESPONDENTS (N = 136)**

Cancer	3.6%	5 respondents
Chronic Pain	19.1%	26 respondents
HIV/AIDS	15.4%	21 respondents
Head Injury	6.6%	9 respondents
Learning Disability	18.4%	25 respondents
Hearing Impairment	9.6%	13 respondents
Sight Impairment	18.4%	25 respondents
Cardio-pulmonary Condition (e.g., heart, lungs)	9.6%	13 respondents
Systematic Condition (e.g., diabetes or “sugar”)	6.6%	9 respondents
Neurological Condition	4.4%	6 respondents
Addiction/Substance Abuse	11.8%	16 respondents
Psychiatric Mental Health	31.6%	43 respondents
Incontinence	4.4%	6 respondents
Enuresis (uncontrolled bladder)	4.4%	6 respondents
Arthritis	17.6%	24 respondents
Autoimmune Condition (e.g., lupus, muscular dystrophy, multiple sclerosis, others)	14.7%	2 respondents
Gastro-intestinal Condition	16.2%	22 respondents
Urinary/Kidney Condition	4.4%	6 respondents
Gynecological Condition	3.6%	5 respondents
Sexually-related Condition	8.8%	12 respondents
Nervous Condition	25.0%	34 respondents
Hearing Aid	0.7%	1 respondents

Other than these exceptions, it is not clear what specific health risks are unique to the transgender community. Survey participants were asked to report health-related concerns that they currently experience. Approximately 60% of the 136 respondents reported having general health problems (82

respondents). Mental health-related concerns comprised a majority of the health concerns. The top three health-related concerns were “family problems,” “feeling sad/depressed,” and “dwelling on problems.” Table 12 lists health concerns reported by transgender respondents in San Diego County.

## ALCOHOL AND ILLEGAL DRUGS

Several national research studies show that the transgender community has a high prevalence of substance abuse. Clements (1999), as cited in Finnegan & McNally (2002), reported that among 392 (m to f) transgender respondents in San Francisco, 16% had received treatment for alcohol abuse and 23% had received treatment for drug abuse. In this same sample, 66% reported using cocaine, 48% reported using “crack,” and 24% reported using heroin. There were also high rates of injection drug use among the sample; 84% of the injectors used methamphetamine.

Results of a 2000 needs assessment project of transgender persons in Washington, D. C., showed that 34% of the sample reported problems with alcohol abuse. In 1998, the Gender Identity Project in New York City reported drug abuse among 23.6% of the sample and alcohol abuse among 27.1% of the sample (Finnegan & McNally 2002).

Stepping Stone, a San Diego substance abuse treatment facility that specializes in treating LGBT clients, reported that transgender clients comprise about 2% of all Stepping Stone clients (Houk 2004).

San Diego County survey participants were asked about their alcohol and drug use behaviors (Table 13). Of the 135 respondents who completed questionnaire items about alcohol use during the past 12 months, 71.1% reported that they used alcohol (96 respondents). Of the 96 respondents who drank, 63.5% reported drinking “once in a while” (61 respondents), 28.1% reported drinking “weekly or more” (27 respondents), and 8.3% reported drinking “daily” (eight respondents). Of those respondents who reported alcohol use, 25% said they “drank too much” (24 respondents); nine reported that “on a typical day” they drank four drinks or more; four reported they got drunk “weekly or more”; and two reported they got drunk “daily.”

When asked how often they had frequented LGBT bars

**Table 12. Health Concerns Reported by Transgender Respondents (N = 136)**

Health Problems	60.2%	82 respondents
Family Problems	55.1%	75 respondents
Sad/Depressed	55.1%	75 respondents
Dwelling on Problems	52.9%	72 respondents
Poor Self-esteem	41.9%	57 respondents
Feeling Lonely	40.4%	55 respondents
Quick Change of Moods	40.4%	55 respondents
Difficulty Sleeping	39.7%	54 respondents
Drawing Away from People	36.0%	49 respondents
Weight Gain	33.8%	46 respondents
Too Much Worry/Nervous	32.4%	44 respondents
Problems Controlling Anger	30.8%	42 respondents
Hard to Trust Anyone	30.1%	41 respondents
Feeling Worthless	29.4%	40 respondents
Less Energy than Usual	29.4%	40 respondents
Feeling Suicidal	28.7%	39 respondents
Negative About the Future	28.7%	39 respondents
Lack Interests or Enjoyment	28.7%	39 respondents
Sexual Problems	27.9%	38 respondents
Problems Controlling Thought	26.5%	36 respondents
Too Many Fears	24.3%	35 respondents
Problems Breathing	24.3%	35 respondents
Feeling Angry/Frustrated	24.3%	33 respondents
Feel Ignored/Abandoned	23.5%	32 respondents
Loss of Appetite	23.5%	32 respondents
Too Much Pain	23.5%	32 respondents
Hard to Make Friends	22.8%	31 respondents
Confused	22.1%	30 respondents
Upset Stomach	22.1%	30 respondents
Feeling Used by Others	22.1%	30 respondents
Restless/Can't Sit Still	21.3%	29 respondents
Loss of Weight	19.9%	27 respondents
Problems with Vision	19.9%	27 respondents
Light-Headed/Dizzy	19.1%	26 respondents
Too Much Alcohol	17.6%	24 respondents
Problems Walking	17.6%	24 respondents
Too Much Tobacco	17.6%	24 respondents
Shaky/Trembling	16.2%	22 respondents
Hot/Cold Spells	15.4%	21 respondents
Problems Hearing	15.4%	21 respondents
Too Many Prescriptions	14.0%	19 respondents
More Energy than Usual	12.5%	17 respondents
Feeling Guilty	9.6%	13 respondents
Too Many Illegal Drugs	3.7%	5 respondents
Nightmares	2.9%	4 respondents

during the past 12 months, 134 respondents reported the following: 34.3% reported they “never” went to a bar (46 respondents), 46.3% reported they went to a bar “once in a while” (62 respondents), 17.9% reported they went to a bar “weekly or more” (24 respondents), and 1.5% reported they went to a bar “daily” (two respondents).

Respondents were asked whether they had used illegal drugs during the past year: marijuana, methamphetamine, cocaine/crack, amyl nitrate, ecstasy, hallucinogens, barbiturates/tranquilizers, heroin, ketamine, g-hydroxybutyrate (GHB), or illegal steroids. The frequency of usage of these drugs is summarized in Table 13. Note that the total number of respondents varies with each drug listed since not all respondents completed all related items.

Respondents were also asked whether they needed services for substance abuse treatment. Table 14 shows that 2.2% reported they “needed but had no access to these services”, 3 respondents).

**Table 13.**  
**Drug and Alcohol Use Reported by Transgender Respondents**

Drug	Never	Once in a While	Weekly or More	Daily
Alcohol	39	61	27	8
Get Drunk	81	47	4	2
Marijuana	105	23	2	3
Methamphetamine	127	7	1	0
Cocaine/Crack	131	3	0	0
Amyl Nitrate	132	3	0	0
Ecstasy	131	4	0	0
Hallucinogens	128	6	0	1
Barbiturates	127	6	2	0
Heroin	135	0	0	0
Ketamine	132	2	0	0
GHB	133	2	0	0
Steroids (illegal)	129	1	3	0

**Table 14.**  
**Need for Substance Abuse Treatment Services (N = 136)**

Need and have access	6
Don't Need	117
Need and No Access	3
Can't Afford	1
Need More Information	3
Services are Not LGBT Friendly	1
Services are Unavailable to Me	0

## TOBACCO

One-fifth of all deaths in the United States today are tobacco-related and half of all people who use tobacco die prematurely. Some studies show that the prevalence of tobacco use may be higher in the LGBT community than in mainstream American society. Stall, et al. (1999) showed that smoking rates were higher among a sample of gay/bisexual men (41.5%) compared with a sample of non-gay/bisexual men (28.6%). Lesbians may smoke more than their gay male counterparts, as evidenced by Skinner and Otis (1996) who demonstrated higher smoking rates for lesbians. Little data are available, however, regarding prevalence rates of tobacco use for transgender persons.

Of the 132 transgender respondents who completed survey items about tobacco use, 33.1% reported being smokers (44 respondents). Of these smokers, 47.7% smoke 10 or more cigarettes per day (21 respondents) and 27.3% smoke 20 or more cigarettes per day (12 respondents). One respondent smoked 45 cigarettes per day.

When those respondents who smoked were asked whether they believed tobacco use was a health concern, 54.5% reported that they used “too much tobacco” (24 respondents), and more than one-third rated tobacco use as a “seriously” or “severely” distressing health concern (nine respondents).

## HIV/AIDS AND TRANSGENDER HEALTH ISSUES

Respondents were asked a set of questions regarding issues of HIV/AIDS. Among these questions was whether respondents ever had an HIV test. Eighty-one percent reported taking an HIV test (110 respondents). Of the 136 respondents who participated in the needs assessment survey, 15.4% reported they were HIV positive (21 respondents) (Table 15). Of the 115 respondents who did not report being HIV positive, 74.8% reported they were HIV negative (89 respondents), 2.6% reported they did not know their HIV status (3 respondents), 1% reported they did not return to the testing site to receive their HIV test results (1 respondent) and 21.7% did not complete the survey item about their HIV test results (25 respondents). Also, of the respondents who did not report being HIV positive (115 respondents), 20.9% had not had an HIV test during the past 3 years (24 respondents), and 4.3%

had not had an HIV test in 10 years or more (5 respondents).

Are the totals of the transgender respondents in this sample who were HIV-positive an *underestimate*? This is not clear because 25 respondents did not report the results of their HIV test. Compared to studies of transgender persons in several other cities, it appears that the reported rates of HIV infection among San Diego’s transgender sample are low (Risser et al. 2002). In other cities these rates are higher, particularly among transgender sex workers. Few local sex workers participated in this study. This may also contribute to a possible underestimate of HIV prevalence among transgender respondents in San Diego County (see also: The Transgender Sex Worker/Barriers to Needs Assessment Participation).

Supporting the assumption that the 25 respondents not answering the HIV status question *chose not* to report their test results is the fact that 21 of them did report taking an HIV test. Thus, it is possible the prevalence of HIV positive respondents is higher than the reported 15.4% who stated they were HIV positive.

Respondents were also asked to rate their risk of contracting HIV or another sexually transmitted disease (STD). Among the 115 respondents who reported they were not HIV-positive, 47% (54 respondents) did report either “some risk” (17.4%, 20 respondents) or “slight risk” (29.6%, 34 respondents) (see Figure 18). Of the respondents who reported they were not HIV-positive, 20 respondents did not respond to this survey item.

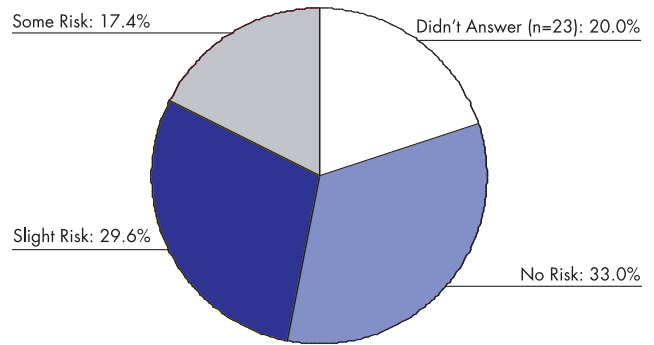
**Table 15. HIV Status of Transgender Respondents**

Took an HIV Test	81.0%, 110 respondents
HIV Negative	74.8%, 89 respondents
HIV Positive	15.4%, 21 respondents
Did Not Return to Receive HIV Test Results	0.7%, 1 respondent
Did Not Report HIV Status on Questionnaire or Did Not Know HIV Status	18.4%, 25 respondents *

\* Twenty-five respondents did not report their HIV status, therefore, prevalence rates of HIV infection among this transgender sample may be an underestimate.

**Figure 18. Risk of Contraction HIV or an STD (n=115)**

Data does not include the 21 respondents who reported they were HIV-positive.



The 21 respondents who reported being HIV-positive were also asked about other HIV-related health issues (Figure 18). Of the 112 respondents who reported their risk of contracting HIV or an STD, 17.9% were respondents who were HIV-positive (20 respondents). Among these 20 HIV-positive respondents, 35% reported they were at “high risk” of contracting an STD (7 respondents), while 15% reported they were at “some risk” (3 respondents), 15% reported they were at “slight risk” (3 respondents) and 35% reported they were at “no risk” (7 respondents).

HIV-positive respondents were also asked whether they were taking anti-retroviral medications for HIV. Sixty-two percent of the HIV-positive respondents reported that they were currently taking these medications (14 respondents), while 14.3% reported they did not take these medications (3 respondents). Two respondents had previously been on anti-retroviral medications, but they are not taking them at this time. Two respondents did not answer items regarding anti-retroviral medications.

HIV-positive respondents were also asked whether they were taking hormones while on the anti-retroviral medication for HIV, and if they were taking hormones, whether their doctors were informed of the medical combination. Of the 14 respondents who reported taking anti-retroviral medications, 92.9% reported they combined hormone therapy with anti-viral medications for HIV (13 respondents). Additionally, 84.6% of the respondents on both anti-retroviral medications for HIV and hormone therapy reported that their doctors knew about the

hormone therapy (11 of 13 respondents), yet only 69.2% of these respondents reported that their doctors discussed medical issues and/or possible dangerous medical interactions related to taking anti-retroviral medications in combination with hormone therapy (9 of 13 respondents).

Respondents who were HIV-positive were asked about their viral load and T-cell count. Overall progress of HIV/AIDS is often measured using these indicators. Most desirable for better health is a higher T-cell count (preferably a T-cell count of 500 or greater) and a lower (or completely undetectable) viral load. Patients receive an AIDS diagnosis once their T-cell count falls below 200, and doctors consider a viral load above 30,000 as an indicator of serious progression of HIV disease (Stine, 2005).

Of the 21 HIV-positive respondents, 14.3% reported a T-cell count below 200 (3 respondents), 33.3% reported a T-cell count between 200 and 499 (7 respondents), and 47.6% reported T-cell counts of 500 or higher (10 respondents). One HIV-positive respondent did not complete the survey item related to T-cell count.

Sixty-seven percent of the respondents who were HIV-positive reported having an undetectable viral load (14 respondents). Only two HIV-positive respondents reported having a viral load greater than 25,000. One HIV-positive respondent did not complete the survey item related to viral load.

Some survey items focused on possible barriers experienced by transgender persons to accessing HIV/AIDS services. The 21 respondents who reported being HIV-positive were asked whether they ever experienced these barriers. Almost one-fourth of the HIV-positive respondents reported that their medical provider was insensitive to transgender issues (5 of 21 respondents), and 19% reported barriers to HIV/AIDS services due to the lack of transgender representation among medical staff (4 respondents). Nearly half of the respondents who were HIV-positive reported they experienced great shame regarding their diagnosis of HIV and that this sense of shame created barriers to accessing HIV/AIDS services (10 respondents).

Respondents were asked whether they needed HIV/AIDS services. Table 16 shows that 5.1% reported they “needed but had no access to these services” (7 respondents).

Finally, analyses were run to look for relationships between

**Table 16. Need for HIV/AIDS Services (N = 136)**

Need and have access	11
Don't Need	108
Need and No Access	7
Can't Afford	7
Need More Information	4
Services are Not LGBT Friendly	1
Services are Unavailable to Me	1

sexual behavior and HIV status of the respondents. Results showed no relationship between HIV status and safer sex behaviors. One's HIV status did not predict safer sex practices nor unsafe behaviors (Chi Square = .82, df = 1, p = 37). There was also no relationship between HIV status and having casual or anonymous sexual partners (Chi Square = 3.3, df = 1, p = .07). Although this figure appears to be close to significance (p = .07), examination of the data showed that if these results were significant, HIV-negative respondents would demonstrate higher rates of casual and anonymous sexual partners than HIV-positive respondents.

There was also no relationship found between illegal drug use behaviors and HIV status of the respondents (Chi Square = .10, df = 1, p = 92).

## SEXUAL BEHAVIOR OF TRANSGENDER RESPONDENTS IN SAN DIEGO COUNTY

### ARE YOU SEXUALLY ACTIVE?/

### DO YOU HAVE A PRIMARY SEXUAL PARTNER?

Transgender respondents were asked whether they had been sexually active during the past 12 months. Of the 136 respondents, 74.3% reported they were sexually active during the past year (101 respondents).

Respondents were also asked specific information about their sexual partners such as the type of sexual partners and the gender of their sexual partners. Type of sexual partner was divided into four categories: primary sexual partner, regular sexual partner, casual sexual partner, and anonymous sexual partner.

A primary sexual partner was defined as one's “significant other.” Of the 136 respondents, 44.9% reported that they had

a primary sexual partner (61 respondents) (Figure 19). The following offers specific information reflecting the gender identification of these 61 respondents and the gender of their primary sexual partner:

- 39.3% identified as “female” (24 respondents) — all 24 respondents were biologically assigned male at birth, with 41.7% reporting that their primary sexual partner was female (10 respondents), 33.3% reporting that their primary sexual partner was male (eight respondents), 12.5% reporting that their primary sexual partner was a male to female (m to f) transgender person (three respondents), and 4.2% reporting that their primary sexual partner was a female to male (f to m) transgender person (one respondent).
- 32.8% identified as “transgender” (20 respondents — of these, 19 were biologically assigned male at birth and one was assigned female at birth, with 55% reporting that their primary partner was a female (11 respondents), 30% reporting their primary partner was a male (six respondents), and 10% reporting that their primary partner was a male to female (m to f) transgender person (two respondents).
- 19.7% identified as “male” (12 respondents) — of these, 10 were biologically assigned female at birth and two were assigned male at birth, with 75% reporting that their primary partner was a female (10 respondents), 16.7% reporting that their primary partner was a male (two respondents), and 8.3% reporting that their primary partner was a male to female (m to f) transgender person (one respondent).
- 4.9% identified as “androgynous” (three respondents) — all were biologically assigned male at birth, with 66.6% reporting that their primary partner was a female (two respondents) and 33.3% reporting that their primary partner was a male (one respondent).
- 3.3% identified as “questioning” (two respondents) — both were biologically assigned male at birth, with one reporting that his primary partner was male and one reporting that his primary partner was female.

## OTHER SEXUAL PARTNERS

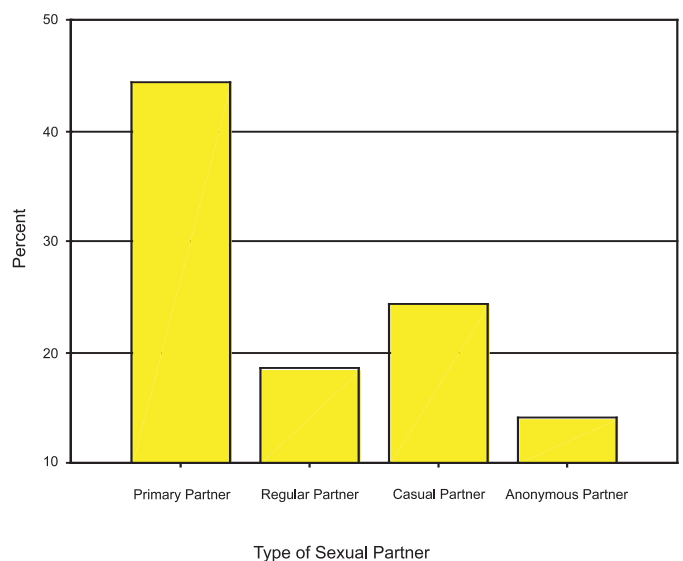
Survey respondents were asked about other sexual partners and associated health risks related to their sexual partners. Other sexual partners included “regular sexual partners,” “casual sexual partners,” and “anonymous sexual partners.” Regular sexual partners were defined as persons with whom one has had sex on a “regular basis.” Casual sexual partners were acquaintances with whom one has had one or more sexual encounters. Non-strangers, or acquaintances, were considered casual partners unless they are regular partners (having sex on a regular basis). Anonymous sexual partners were strangers to the survey participant at the time of the sexual encounter.

Of the 136 respondents, 18.4% reported having regular sexual partners (25 respondents), 25% reported having casual sexual partners (34 respondents), and 14% reported having anonymous sexual partners (19 respondents) during the past year (Figure 19). These data included respondents who had multiple combinations of sex partner types.

The following provides additional information about the types and frequency of sexual partners of sexually active respondents:

- Of the 25 respondents who reported having regular sexual partners during the past year, 52% reported having only one regular sexual partner (13 respondents), 32% reported having two regular sexual partners (eight respondents), 8% reported having four regular sexual partners (two respondents), one respondent reported having five regular sexual

Figure 19. Type of Sexual Partner for Transgender Respondents (n = 136)



partners, and one respondent reported having 30 regular sexual partners.

- Of the 34 respondents who reported having casual sexual partners during the past year, 29.4% reported having one casual sexual partner (10 respondents), 20.6% reported having two casual sexual partners (seven respondents), 41.3% reported having between three and six casual sexual partners (14 respondents), one reported having 15 casual sexual partners, one reported having 20 casual sexual partners, and one reported having 75 casual sexual partners.
- Of the 19 respondents who reported having anonymous sexual partners during the past year, 31.6% reported having one anonymous sexual partner (six respondents), 15.8% reported having two to three anonymous sexual partners (three respondent), 10.6% reported having five to nine anonymous sexual partners (two respondents), 15.8% reported having 10 anonymous sexual partners (three respondents), 10.5% reported having 20 anonymous sexual partners (two respondents), 10.5% reported having 100 anonymous sexual partners (two respondents), and one respondent reported having 200 anonymous sexual partners.

### **SEXUAL RISK BEHAVIOR (SEE ALSO SECTION ON HIV/AIDS IN HEALTH CONCERNS)**

Respondents were asked questions regarding their sexual risk behaviors such as their perceived risk of contracting HIV or STDs. Of the 112 respondents who answered questions about this issue, 59.8% reported they were at some level of risk of contracting HIV or STDs (67 respondents).

When asked whether they had contracted an STD during the past five years, respondents reported contracting the following: syphilis (two respondents), chlamydia (four respondents), HPV (five respondents), gonorrhea (two respondents), and herpes (two respondents). Twenty-one respondents reported they were HIV-positive.

Respondents were also asked whether or not they had engaged in unprotected sexual intercourse during the past 12 months. Of the 135 respondents who completed this survey item, 39.3% reported having unprotected sexual intercourse

during the past 12 months (53 respondents), as indicated in the following:

- 28 respondents reported having unprotected sexual intercourse with their primary sexual partners
- 12 respondents reported having unprotected sexual intercourse with their regular sexual partners
- Nine respondents reported having unprotected sexual intercourse with their casual sexual partners
- Four respondents reported having unprotected sexual intercourse with their anonymous sexual partners
- As much as 61.5% reported having unprotected oral sex during the past 12 months (83 respondents).

### **THE TRANSGENDER SEX WORKER/BARRIERS TO NEEDS ASSESSMENT PARTICIPATION**

Several recent studies support the belief that there is a high prevalence of sex workers among transgender persons. A 1998 San Francisco study showed that out of a sample of 392 (m to f) transgender persons, 32% were sex workers (White & Townsend 1998). Additional data from a 2002 transgender healthcare needs assessment in Houston, Texas, involving 67 (m to f) transgender respondents showed that 50% of a sample engaged in sex work behaviors (Risser et al. 2002). Clients at North Park Family Health Center's Tuesday night clinic have substantiated that belief since a substantial number of these clients are transgender sex workers.

The reason for this high prevalence rate is unclear. A history of unfavorable childhood experiences, gender identity issues, low self-esteem, depression, barriers to education, social stigma, and discrimination in the workplace have all been cited as possible explanations. Too little research exists, however, and therefore much remains to be understood.

A typical profile of a transgender sex worker is often someone who presented their true gender at an early age. As a result they experience much social alienation including being ostracized and ridiculed by friends and family. Many leave home prematurely and thus these individuals lack some social development necessary for competence in adulthood (e.g., ability to succeed in an employment situation). For many of these

individuals, sex work becomes a viable means to an end — food, shelter, clothing, hormone therapy, and medical treatment including SRS. Transgender sex workers may also experience sex work as validation of their own transgender emergence.

The research literature also supports the notion that transgender youth often engage in sex worker behavior, and this places them at great risk. Transgender youth are at risk for sexual exploitation, HIV/STDs, and street violence because they are very likely to engage in prostitution and substance abuse, which is linked to prostitution. They are also likely to be runaways and/or homeless. These youth are very unlikely to engage in safe sex behaviors (Denny 2004).

Sex workers appear to have higher rates of HIV infection than non-sex workers. Social stigma, life stresses, and violence may reduce access to healthcare and impede safer sex abilities of transgender sex workers. A 1998 study in Atlanta among sex workers showed that 68% tested HIV positive (UCSF AIDS Institute 2001). A 1998 study in Hollywood, California, surveyed 209 (m to f) transgender persons and found that sexual risk behaviors were significantly greater among sex workers compared with non-sex workers. Several international studies reported rates of HIV infection as high as 74% among transgender sex workers (Risser et al. 2002).

Outreach workers experienced enormous difficulties in recruiting transgender sex workers for the San Diego County Transgender Healthcare Needs Assessment. Many barriers to participation were evident, mainly because of a lack of trust among transgender sex workers and mainstream government organizations and healthcare institutions. Trust also appears to be an issue with LGBT provider organizations.

According to a qualitative interview with a local (m to f) transgender sex worker, there is little integration or assimilation among transgender sex workers and the health profession. Many transgender sex workers have significant arrest histories and are therefore hesitant to be “open” about sharing their life experiences. Healthcare providers may be perceived as a link to a legal system, even if only by an irrational or emotional association. The interviewee, who has lived as a sex worker in several other cities, stated that this was particularly true of transgender sex workers in San Diego County. She thought there were greater distrust issues among sex workers in San Diego County than in other places she had lived. “The girls

don’t trust anyone, even each other,” she reported.

Also, according to this interviewee, there is little integration of transgender sex workers within the LGBT community or the larger transgender community of San Diego County. The interviewee reported, “...the girls don’t hang out with any group, gay, straight, or even other girls [(m to f) transgenders].” She stated several reasons for this:

- Distrust of legal authorities in San Diego County
- Distrust of healthcare providers in San Diego County, including alleged “LGBT-friendly” healthcare services
- A lack of strong transgender presence in local LGBT organizations
- Perceived social stigma toward sex workers in San Diego’s LGBT community
- Lack of social assimilation of transgender sex workers within the larger transgender community in San Diego County
- A high level of competition and feelings of distrust among local transgender sex workers toward each other (pressure to succeed economically may impede the building of social support within the sex worker cohort)
- General economic frustration and stress living in San Diego County, perhaps related to the high cost of living

Three survey participants reported that they were employed as a sex worker. Apparently three transgender sex workers in a survey of 136 participants is an *extreme underestimation* of transgender sex worker representation. According to key informant leaders in the transgender community and the transgender sex worker interviewee, many local transgender sex workers refused to participate in the needs assessment study. It was estimated that 25 to 30 transgender sex workers would have been recruited for this study had barriers to participation not been present, and almost all of them were (m to f) transgender persons.

Of the three transgender sex workers who participated in this study, two identified as “female” and one identified as a “transgender person.” All were biologically assigned “male” at birth. All three respondents reported having hundreds of

anonymous sexual partners during the past 12 months. None of the sex workers reported having other types of sexual partners during the past year such as a primary sexual partner, regular sexual partners, or casual sexual partners.

The respondents were asked whether they had unprotected sexual intercourse with their anonymous sexual partners during the past year. Only one of the three sex workers reported having unprotected sexual intercourse or unprotected oral sex. The sex worker who engaged in unprotected sexual behavior did not state how frequently unprotected sex occurred.

Regarding other sexual health risks, the same respondent who reported having unprotected sex also reported having contracted an STD during the past five years. None of the three sex worker respondents completed survey items about their HIV status.

## **RECOMMENDATIONS: PRIORITIZATION OF SERVICE AND PROGRAM NEEDS**

Following a review of the needs assessment data and reviews by members of the Transgender Healthcare Needs Assessment Advisory Committee, staff at Family Health Centers of San Diego and other professionals in the field, the following recommendations are being made for the prioritization and planning of transgender services in San Diego County:

### **1. LEADERSHIP AND A TRANSGENDER COMMUNITY PLANNING GROUP.**

Family Health Centers, the lead agency of this needs assessment study, should convene a community planning group comprised of transgender community leaders, community members and healthcare and social service providers, to prioritize and implement the recommendations of the needs assessment. The community planning group should focus on ensuring the development of culturally appropriate programs and services for San Diego's transgender community. Under the leadership of Family Health Centers, the community planning group should begin to seek appropriate funding to support new and existing programs and service.

### **2. EDUCATION.**

The needs assessment data revealed that transgender persons are faced with many barriers to the successful completion of their education, demonstrating the need for specialized educational programs and services. The community planning group should develop a relationship between the transgender community and the local educational systems. A transgender student advocacy organization should be founded consisting of transgender students, health providers, school counselors and other educators. Educational development and technical assistance to counseling programs in the San Diego County schools may help educators regarding key issues related to the transgender emergence: life stages of transgender development, family issues, mental health issues, and cultural issues. Within a collaborative relationship with local educators, a plan to diminish barriers to education may be better explored. Additionally, relationships should be formed with local universities and community colleges resulting in an expanded student advocacy organization for advanced education (community college, college and graduate school). Financial aid and scholarship programs may enhance the work of the student advocacy association established for advanced education.

### **3. EMPLOYMENT.**

Data from the local needs assessment identified high rates of unemployment among transgender respondents. There is a need for employment preparedness services including job counseling, skills training and job placement to assist transgender persons in gaining and maintaining employment. Counseling, skills training and job placement services should be respectful of the cultural sensitivities of transgender persons. In addition, San Diego businesses, government, and social service organizations should be encouraged to participate in education inservices and cultural competency classes related to transgender community issues. This could help reduce workplace discrimination, social stigma and hostility experienced by many transgender persons.

### **4. MENTAL HEALTH / SUICIDE PREVENTION.**

Local mental health agencies should be encouraged to increase their capacity for mental health counseling services

to San Diego's transgender community. There is a need for more counselors trained and certified in specific clinical needs of transgender clients. The recruitment of qualified counselors who are transgender persons is also encouraged. A priority of the mental health community should be the issue of suicide prevention. Data from the local needs assessment identified high rates of suicidal ideation among transgender respondents. Through social marketing efforts, access to a suicide hotline should be visibly targeted to the transgender community, and special training in transgender-specific clinical issues should be provided for those who staff for these suicide hotlines. Programs and services that provide increased community awareness of suicide and suicide prevention for the transgender community are needed.

#### **5. SEXUAL RISK BEHAVIORS / SPECIAL NEEDS OF TRANSGENDER SEX WORKERS.**

The struggle for one's authentic sense of gender identity entails a process that unfolds over many years for many transgender persons. As transgender persons become sexually active adults, issues of gender identity and gender identity confusion can result in sexual experimentation and high rates of risky sexual behaviors. HIV/STD prevention interventions and programs that specifically target transgender persons and their unique needs are needed. Qualitative data from transgender sex worker interviews demonstrated issues of "trust" as a key barrier regarding health service delivery to transgender sex workers. Special programs and services that establish trusting relationships with transgender sex workers and provide increased access and delivery of healthcare services to them, particularly in HIV/STD prevention, should be developed.

#### **6. FINANCIAL RESOURCES FOR SEXUAL REASSIGNMENT SURGERY (SRS).**

Results of the local needs assessment demonstrated the enormous amount of personal and financial resources that are invested in SRS. For many, the cost of SRS is a barrier that cannot be overcome. For those who someday desire SRS, yet cannot afford it, there may be unrelenting emotional pain and dissatisfaction. Information about SRS

and other medical procedures should be readily available to interested transgender clients. Programs and services that educate clients, assist them in realistic financial planning for SRS and other medical procedures and provide supportive counseling would be a valuable community resource.

#### **7. IMPROVED PUBLIC RELATIONS WITH HEALTHCARE PROVIDERS / INCREASE CAPACITY IN MAINSTREAM HEALTHCARE SERVICE ORGANIZATIONS.**

Mainstream healthcare service providers should encourage and facilitate increased participation of transgender clients within the programs and services they provide. Stakeholders who currently provide programs and services for transgender clients may help form collaborative agreements with other existing mainstream service organizations for the purpose of increasing capacity for services in which transgender clients may comfortably participate. Education and cultural competency training for these mainstream healthcare service providers could result in increased culturally sensitive programs and services available to the transgender community.

#### **8. INCREASE CAPACITY IN LGBT PROVIDER ORGANIZATIONS.**

LGBT community-based organizations that deliver services to culturally diverse groups should increase participation of transgender clients in their general programs and community events. This may require that organizations develop ways to increase access to transgender clients and create programming that is culturally sensitive to unique needs of the transgender community.

#### **9. COMMUNITY ADVOCACY FOR CIVIL RIGHTS.**

Community advocacy for civil rights related to transgender issues should be a priority. Advocacy should focus on some of the following issues: employment discrimination, workplace discrimination, housing discrimination, hate crime violence, increased insurance coverage for transgender-related medical issues, legal consultation for transgender related issues and transgender representation in public policy.

## REFERENCES

- Always Your Choice. 2003. Gay men: Homophobia and health care; <http://www.alwaysyourchoice.com/aye/sex/gay/homophobia.php>.
- Berger, R. 1995. *Gay and gray: The older homosexual man* (2nd ed.). New York: Hawthorn Press.
- Broadhead, W. E., B. H. Kaplan, S. A. James, E. H. Wagner, V. J. Schoenback, R. Gimson, S. Heyden, G. Tibblin, and S. H. Gehlback. 1983. The epidemiological evidence for a relationship between social support and health. *American Journal of Epidemiology*, 117, no. 5:521–537.
- Bruhn, J. G., and G. U. Philips. 1984. Measuring social support: A synthesis of current approaches. *Journal of Behavioral Medicine*, 7, no. 2:151–169.
- Bullough, B., Bullough, V. L., and Elias, J. 1997. *Gender Blending*. New York: Prometheus Press.
- Butler, S. S. 2002. Guest editor's message: Geriatric care management with sexual minorities. *Geriatric Care Management Journal* 12, no. 3:2–3.
- Carroll, L., P. J. Gilroy, and J. Ryan. 2002. Counseling transgendered, transsexual and gender-variant clients. *Journal of Counseling and Development*, 80:131–139.
- Cahill, S., K. South, and J. Spade. 2000. *Outing Age: Public policy issues affecting gay, lesbian, bisexual, and transgender elders*. Washington, D.C.: Policy Institute, National Lesbian & Gay Task Force.
- Canadian Union of Public Employees. November 17, 2003. Violence against transsexual and transgender persons; <http://cupe.ca/www/equalityPride/8676>.
- Clements, K. 1999. *The transgender community health project: Descriptive results*. An informational report from the San Francisco Department of Public Health.
- Conway, L. (2005). Vaginoplasty: Male to female sex reassignment surgery; <http://ai.eecs.umich.edu/people/conway/TS/SRS.html>.
- Davis, C. L. 1998. *Service needs, availability and satisfaction among lesbians age 40+*. (Unpublished manuscript, Gerontology, College of Nursing, University of Utah.)
- Dean, L., I. Meyer, K. Robinson, R. Sell, R. Sember, V. Silenzio, D. Wolf, D. J. Bowen, J. Bradford, E. Rothblum, D. Staut, J. White, and P. Dunn. 2000. *Lesbian, Gay, Bisexual and Transgender Health: Findings and Concerns*. Gay and Lesbian Medical Association and the Center for LGBT Health, Columbia University's Joseph L. Mailman School of Public Health. New York City.
- Denny, D. 2004. Transgendered youth at risk for exploitation, HIV, hate crimes. *Inner-Q-Zone*. <http://www.aidsinfonyc.org/Q-zone/youth.html>.
- Estey, J., and M. Bursaw. 1998. *Needs assessment of the lesbian, gay, bisexual & transgender communities of San Diego County*. Informational booklet from the San Diego Human Dignity Foundation. San Diego, Calif.
- Feinberg, L. 1998. *Transliberation: Beyond pink or blue*. Boston: Beacon Press.
- Finnegan, D. G., and E. B. McNally. 2002. *Counseling lesbian, gay, bisexual and transgender substance abusers*. New York: Hawthorn Press.
- Healy, T. 2002. Culturally competent practice with elderly lesbians. *Geriatric Care Management Journal* 12, no. 3:9–13.
- Holahan, C.K. and C.J. Holahan. 1987. Self-efficacy, social support and depression in aging: A longitudinal analysis. *Journal of Gerontology*, 42, 65–68.
- Houk, C. 2004. Executive Director, Stepping Stone, Inc., San Diego, Calif. Personal communication, December 2, 2004.
- Hunter, J., and G. P. Mallon. 1998. Social work practice with gay men and lesbians within their communities. In G. P. Mallon (ed.), *Foundations of Social Work Practice with Lesbian and Gay Persons*, 229–248. New York: Hayword Press.
- Kaiser Permanente. 2000. *Providers Handbook on Culturally Competent Care: Lesbian, Gay, Bisexual & Transgendered Population*. National Diversity Department, Kaiser Permanente, Oakland, Calif.

- Lev, A. I. 2004. *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. New York: The Hawthorn Clinical Practice Press.
- McVinney, D. L. 1998. Social work practice with gay male couples. In G. P. Mallon (ed.), *Foundations of Social Work Practice with Lesbian and Gay Persons*, 209–227. New York: Hayword Press.
- Meyer, J. 1990. Guess who is coming to dinner this time? A study of gay intimate relationships and the support for those relationships. In F. W. Bozette and M. B. Sussman (eds.), *Homosexuality and Family Relations*, 59–82. Binghamton, N.Y.: Harrington Park Press.
- Neugarten, B.L., R.J. Havinghurst, & S.S. Tobin. 1961. The measurement of life satisfaction. *Journal of Gerontology*, 16, 134-143.
- Pierce, K. 1999. Director, *Boys Don't Cry* (Motion Picture). United States: Fox Searchlight Pictures.
- Ralston, R. July 14, 2005. Women Injected with Silicone at 'Pumping Party' Dies. *Gay & Lesbian Times*, San Diego, CA.
- Risser, J. M. H., A. J. Shelton, M. Williams, S. McCurdy, B. Thomas, P. Padgett, B. Useche, J. Atkinson, and Z.C. Larry. 2002. *Behavioral assessment of the transgender population, Houston, Texas*. Informational booklet from the University of Texas, School of Public Health. Houston.
- San Diego Association of Governments (SANDAG). 2002. Demographics and Other Data. <http://www.sandag.org/resources/demographics/estimates>.
- Sarason, I. G. 1980. Life stress, self-preoccupation and social supports. In I. G. Sarason & C. D. Spielberg (eds.), *Stress and Anxiety*, 73–94. New York: Hemisphere Publishing.
- Shapiro, J. 1991. Transexualism: Reflections of the persistence of gender and the mutability of sex. In J. Epstein and J. Straub (eds.), *Body Guards: The Culture Politics of Gender Ambiguity*, 248–279. New York: Routledge.
- Skinner, W. F., and M. D. Ottis. 1996. Drug and alcohol use among lesbians and gay people in a southern U. S. sample: Epidemiological, comparative, and methodological findings from the Trilogy Project. *Journal of Homosexuality*, 30, 3:59–92.
- Solarz, A. L. 1999. *Lesbian Health: Current Assessment and Directions for the Future*. Washington, D.C.: National Academy Press, Institute of Medicine.
- Stall, R. D., G. L. Greenwood, M. Acree, J. Paul, and T. J. Coates. 1999. Cigarette smoking among gay and bisexual men. *American Journal of Public Health*, 89, 12:1875–1878.
- Stine, G. 2005. *AIDS Update 2005*. San Francisco: Pearson Benjamin Cummings
- U.S. Census Bureau, California Quick Facts, 2003. <http://www.quickfacts.census.gov/qfd/states/0600.html>
- UCSF AIDS Research Institute. 2001.
- Venturi Staffing Partners. November 2004. <http://venturistaffing.com/sd-ui.shtml>.
- Wakefield, J. C. 1992. Disorder as harmful dysfunction: A conceptual critique of DSM-III-R's definition of mental disorder. *Psychological Review*, 99, 232–247.
- White, S. C. and Townsend, M. H. 1998. Transgender medicine: Issues and definitions. *Journal of the Gay and Lesbian Medical Association*. 2, 1-3.
- Whittle, S. 1995. *Transsexuals and the Law*. Doctoral thesis. Manchester, England: Manchester Metropolitan University (as cited in Lev, 2004).
- Witeck-Combs Communications. 2002. Fewer than half of all lesbian, gay, bisexual, and transgender adults surveyed say they have disclosed their sexual orientation to their health care provider. December 2002. Harris Interactive Survey. Rochester, N.Y. <http://www.harrisinteractivie.com>.
- Zians, J. 2004. *The San Diego County LGBT senior health care needs assessment*. Informational booklet from The Alliance Healthcare Foundation. San Diego, Calif.