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Common barriers to healthcare for transgender people in the U.S. Southeast

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ABSTRACT

Background: Transgender and non-binary people are more likely to face barriers to healthcare than their cisgender counterparts. The majority of work in this area centers on the experiences of transgender people in northern cities and urban enclaves, yet over 500,000 transgender people live in the U.S. Southeast.

Aims: The purpose of this study is to explore barriers to healthcare among transgender people in the U.S. Southeast.

Methods: The research team conducted four 120-minute focus groups (eligibility criteria: 18 years or older, self-identify as transgender, live in the U.S. Southeast). Participants completed a demographic questionnaire prior to the start of the focus group. Each focus group explored access to and experiences of receiving basic healthcare as a transgender person in the U.S. Southeast. Established qualitative methods were used to conduct the focus groups and data analysis.

Results: Participants ($n=48$) ranged in age from 19 to 65, with the majority identifying as trans women (43.8%) and non-binary (33.3%). The sample was racially diverse: White (50%), Black (37.5%), and Latinx or Multiracial (12.5%). Multiple barriers to care were identified: (1) fear and mistrust of providers; (2) inconsistency in access to healthcare; (3) disrespect from providers; and, (4) mistreatment due to intersecting experiences of gender, race, class, and location.

Discussion: Transgender Southerners face barriers to care at the structural, cultural, and interpersonal levels. The study results have implications for researchers, as well as providers, practices, and health care systems throughout the region.

KEYWORDS

Barriers to care; focus group; health; non-binary; transgender; U.S. Southeast

Introduction

Recent estimates suggest that over 500,000 transgender adults reside in the southeastern region of the country. While trans people throughout the United States experience daily hardship as a result of transphobic or cissexist stigma, prejudice, and discrimination (Heng, Heal, Banks, & Preston, 2018; Salkas, Conniff, & Budge, 2018), trans southerners do so in a region that is marked by its rurality (Abelson, 2019) and its heightened conservatism and evangelicalism (Barton, 2012; Campbell, Hinton, & Anderson, 2019; Rogers, 2019; Sumerau, Cragun, & Mathers, 2016). In addition to the cultural barriers to trans acceptance in the South, trans southerners are also affected by the region's high unemployment rates, low wages, and a lack of public services such as transportation, healthcare, and housing.

A 2018 review of the sociological literature on trans experience revealed that while one-third of trans adults in the U.S. reside in the southeast region of the country, only one-tenth of the sociological studies of transgender life focus on the experiences of trans southerners (Stone, 2018). Yet, regional barriers position trans southerners at a unique disadvantage across social contexts and institutions, including those related to health and healthcare. According to recent studies on transgender life, trans people in the United States experience disproportionate disparities accessing care and are more likely to experience negative outcomes related to both physical and mental health (Salkas et al., 2018; Seelman, Young, Tesene, Alvarez-Hernandez, & Kattari, 2017; Wright et al., 2018). The limited research on trans health in the south suggests that these

negative outcomes are heightened for trans southerners (Harless, Nanney, Johnson, Polaski, & Beach-Ferrara, 2019).

Health outcomes of stigma and discrimination

Meyer's (2003) "minority stress" perspective outlines the pathways from stigma and discrimination to poor mental health outcomes among sexual minorities (e.g., lesbian, gay, and bisexual people). The minority stress model suggests that social stigma results in identity-based discrimination for LGB people (e.g., homophobia, heterosexism) that is uniquely harmful to their mental and physical health (Frost, Lehavot, & Meyer, 2015). Hendricks and Testa (2012) applied this perspective to gender minorities, suggesting that the social sanctions associated with gender transgression result in negative mental health outcomes for trans people. Indeed, this position was affirmed by Pega and colleagues in their (2015) call for the World Health Organization to designate gender identity a social determinant of health: "Prejudice, stigma, transphobia, discrimination, and violence targeted at transgender people produce differential levels of social exclusion for populations defined by gender identity" (Pega & Veale, 2015, p. e59). These social exclusions impact individuals in ways that scholars argue are affecting both mental and physical health.

Transgender experiences in health care settings

Transgender people's experiences of stigma and discrimination often occur within healthcare settings (Brown, Kucharska, & Marczak, 2018; Hilário, 2018; Hughto, Reisner, & Pachankis, 2015; Miller & Grollman, 2015). Providers often lack education regarding trans experiences leading them to approach trans healthcare with uncertainty or deny healthcare to trans patients altogether (Holt, Hope, Mocarski, & Woodruff, 2019; Kenagy, 2005; Sequeira, Chakraborti, & Panunti, 2012). In the absence of formal education, normative ideological assumptions replace a standardized curriculum about trans patients' identities and healthcare needs, compromising trans patients' access to care by enforcing cultural stereotypes that eclipse individual experiences of

gender, health, and the body (Johnson, 2015b, 2016). Trans patients learn to negotiate these experiences or risk losing access to care (Johnson, 2019).

When trans patients are allowed into practices, they are met with harassment, misgendering, and objectification (Nordmarken & Kelly, 2014; Shires & Jaffee, 2015). These barriers to care often influence trans peoples' desire to seek care and their comfort in care settings (Lerner & Robles, 2017). Research suggests that several factors may lead a trans person to delay or avoid seeking care: they may have had negative experiences in the past (Cruz, 2014; Poteat, German, & Kerrigan, 2013); they may fear that providers in their area lack knowledge of trans experience and health (Bauer et al., 2009); they may not want to deal with trans insensitivity at intake, on office and insurance forms, and within the normatively gendered structure or social environment of their provider's office (Redfern & Sinclair, 2014). In 2016 the National Center for Transgender Equality (NCTE) released their report of the U.S. Trans Survey (James et al., 2016). Of the 27,715 respondents, 23% did not seek healthcare due to fear of mistreatment, a fear that likely stems from past experience as 33% reported mistreatment from a provider in the prior year. Other research suggests this estimate may be conservative: 33% of trans people in one study (Poteat et al., 2013) and 39% in another (Reisner et al., 2015) delayed healthcare due to fear of mistreatment. Stigma and discrimination often result in delays seeking treatment among trans people (Reisner, Radix, & Deutsch, 2016), with the main reason being a desire to limit stigmatizing events and discrimination (Cruz, 2014).

Trans southerners

According to the Williams Institute, approximately 500,000 trans people live in the South (Flores, Herman, Gates, & Brown, 2016). Yet, the majority of research on trans people focuses on northern and coastal urban enclaves (Stone, 2018). This oversight is problematic considering the elevated minority stressors and threats to trans health in the region (Bradford, Reisner, Honnold, & Xavier, 2013; Rogers, 2018). In the

South, LGBTQ people as a group must reckon with homophobia and transphobia in a region defined by its social and political conservatism, heightened evangelicalism, high unemployment, and rurality. While cisgender gay and lesbian people are gaining some traction in the region in terms of social acceptance, researchers studying this population reveal that this acceptance is not necessarily available to transgender and gender diverse people (Cragun & Sumerau, 2015; Mathers, Sumerau, & Cragun, 2018).

Due to this increased oppression and stigma (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013), one study found that over 50% of trans people in the South of the US had experienced suicidal ideations (Harless et al., 2019). In the Southeast, trans people experience difficulty finding appropriate mental healthcare and are often forced to turn to other trans people for support and resources (Rogers, 2018). Along with increased stressors, risks to health, and lack of competent providers in the region, trans Southerners are also more likely to live in poverty and less likely to have health insurance further threatening their access to the physical healthcare that they need (Bishaw, 2014).

Methods

This article uses focus group interviews to examine common barriers to care affecting trans Southerners. Our research team completed four semi-structured focus group interviews, with 48 trans and non-binary people across the Southeast, focused on their experiences seeking and receiving healthcare. The focus groups took place in North Carolina, South Carolina, Tennessee, and Alabama and included participants from these states as well as from Mississippi and Arkansas. Participants were recruited through Facebook and local community organizations serving trans and non-binary people. Participants were eligible to participate if they self-identified as transgender, lived in the U.S. Southeast, and were 18 years of age or older. This research was approved by the IRB at Kenyon College in Gambier, Ohio, USA and written informed consent was secured. In exchange for participation, participants received a \$50 Prepaid Visa Gift

Card. Each interview lasted approximately two hours and centered on two discussion prompts: (1) How would you describe access to healthcare for trans and non-binary people in the South? and (2) What has been your experience accessing healthcare as a trans and non-binary person in the South? When conversation stalled, prompts were introduced. For example: “Can you think of a particularly memorable experience related to accessing healthcare in the South as a trans or non-binary person?” For each interview two research team members moderated, one served as notetaker, the other as facilitator. As each new theme emerged, the facilitator polled the group to determine prevalence of experiences and noted any contradictory experiences.

For analysis, we used an inductive coding method (Charmaz, 2005, 2006). We completed audiovisual recordings and secured transcription of all focus groups. The two lead authors initiated independent open coding, tagging every topic that arose in the interviews. They then compared codes for intercoder reliability, used refined coding to integrate the codes into a thematic schema, re-coded all interviews based on the new schema, and created a set of memos pulling together disparate pieces of data from each of the codes. In line with transfeminist methodology (Johnson, 2015a), we reflected on the ways that our identities might impact the research process. We worked to ensure a comfortable and affirming atmosphere at each focus group. Our research team included six people, three of whom identified as trans, including the first two authors of this article who served as co-principal investigators. Experience working with trans community among our research team members ranged from 2 to 15 years.

Results

The focus group interviews revealed barriers to healthcare for trans and non-binary Southerners including: (1) patient fear and mistrust of providers; (2) inconsistency in treatment availability; (3) disrespect and insensitivity; and, (4) mistreatment as a result of intersecting social identities and circumstances. These themes reached consensus among focus group participants as common among

Table 1. Participant demographics.

Gender identity	
Trans woman	21
Trans man	9
Non-binary/ gender non-conforming	16
Did not answer	2
Race	
Black	18
Latinx	1
Multi-racial	5
White	24
Age	
18–24	15
25–34	18
35–44	9
45–54	1
55+	5
Level of education	
Less than high school diploma	21
High school diploma or equivalent	4
Two-year degree	12
Four-year degree	8
Graduate or professional degree	3
Household income	
less than \$15,000 per year	17
\$15,000–\$30,000 per year	17
\$30,000–\$50,000 per year	9
\$50,000–\$75,000 per year	3
more than \$75,000 per year	2
Health insurance status	
Uninsured	16
Medicaid/medicare	7
Insured through employer	13
Insured through healthcare.gov	11

trans and gender diverse Southerners. Participant demographics may be found in [Table 1](#).

Fear and mistrust

Existing research reveals patterns of mistrust among trans and gender diverse patients regarding the ability to access physicians who will treat them with dignity and respect (Kosenko, Rintamaki, Raney, & Maness, 2013). Participants across all focus groups expressed fear of and mistrust in providers. One participant aptly stated:

My primary concern is not ... if my gender identity is going to be a problem ... it is am I going to be helped regardless of it?

Trans and gender diverse people experience disproportionate rates of psychological distress, often resulting from their experiences of stigma and discrimination (Hendricks & Testa, 2012; Rimes, Goodship, Ussher, Baker, & West, 2019). This psychological distress is likely exacerbated by interactions with healthcare itself as participants in each group described experiencing

anxiety leading up to appointments. One participant shared:

Going to the doctor is completely anxiety producing and scary ... not a lot of hope that it is going to turn out okay. Kind of expecting the worst. Every time I would call...I would expect not to have my pronouns respected or [for them not to] understand issues. Going in I know I am going to have to explain things ... I'd rather not take that chance.

Inconsistency

Participants reported inconsistent access to healthcare and long wait times, often due to providers being over-extended as the only provider in the area willing to treat trans and non-binary patients. These providers often took on trans and non-binary patients even when their practice was at capacity leading to inconsistent availability of appointments:

I think most of the primary care providers are really over-extended. There are a few of them here... but it's really hard to get into any of them. And, a lot of them, their practice isn't accepting new patients unless you are trans. And it's still a wait because there's an enormously high percentage of trans people in this city. There are providers, but there are not enough providers to serve all the trans people who live here.

Additionally, when their primary physician was away or when participants had emergent or immediate healthcare needs, they were often treated by providers who were not as educated or affirming. One participant stated:

You have a UTI and you can't get in to see your PCP [primary care provider] so you have to go to urgent care and see whoever is working. You never know who is going to be on location. I [went to my primary clinic] not long after gender reassignment surgery, because I thought I had an infection. I kept trying to see my PCP, but they made me come to urgent care. When the guy who came to see me figured out what was going on, he started to sweat and really didn't handle it well.

This additional stress when dealing with immediate healthcare needs only adds to the negative experiences of trans and gender diverse patients in the region.

Disrespect

Front desk and nursing staff are the first lines of communication between patient and provider

and have a significant impact on patients' comfort in a healthcare setting (Blanchard & Lurie, 2004). Participants reported that these interactions often resulted in disrespectful and insensitive treatment in the form of misgendering (i.e., being referred to using incorrect gendered pronouns and language) and verbal harassment in ways that resulted in further alienation from healthcare. One participant, who recently accompanied another trans person to a local clinic, shared the following experience:

There was a transgender lady trying to get in and called the office. They did not respect her pronouns, and she corrected them multiple times. It was horrible, but then when she got back to the exam room, this is just the front desk... when she got to the back, there were [negative] conversations about her being held on the other side of the door that she could overhear.

There is still a significant amount of stigma attached to trans and gender diverse experiences, and our participants felt the effects of that stigma as they were stared at, whispered about, misgendered, and at times harassed by other patients and administrative or clinical staff. Some of these experiences result in the mismanagement of healthcare, leading to complications:

When I first came out I was gender fluid and I used he/they pronouns. I broke my foot and I went to physical therapy and they wouldn't respect my pronouns at all.... They would change me a lot [to different physical therapists].... because they were tired of me telling them to use the right pronouns.... So, I stopped [physical therapy] and now my foot is hurt really badly. Walking hurts. My full body hurts from adverse reactions to that. All because I didn't complete physical therapy, because I was too nervous to go because of that.

For some participants, interactional mistreatment resulted in a delay or avoidance of healthcare altogether. Others continued to seek healthcare, accepting mistreatment from providers and support staff, fearing they would lose access to healthcare if they stood up for themselves. One participant explained this fear:

A lot of transgender people are afraid to speak up or be direct. If you want to correct people or stand up for yourself, you always have that fear... "Oh God, that could risk me getting my hormones, what if she refused to treat me or refused to help me with this." So, you just sit in it and then you try to go on.

Being forced to sit through stigmatizing experiences like this can lead to further stress and negative health outcomes.

Intersecting barriers

Trans and gender diverse people in the South live multidimensional lives that are affected not only by their gender identities, but also by their socioeconomic status, race, age, and geographic location. Every participant we spoke with experienced these layered barriers to care. Trans and gender diverse people who face financial hardship are more likely to face difficulties maintaining a healthcare relationship with a provider and may delay healthcare to avoid the financial burden that comes with being under- or uninsured. Many participants dealt with their financial barriers on a case-by-case basis. They were forced to decide if their healthcare problem was serious enough to risk further financial hardship. This often meant not seeking medical attention when it was needed.

Racism also impacts the healthcare experiences of trans and gender diverse people of color (POC) in the South in similar ways to those that have been documented for trans and gender diverse POC across the United States (James et al., 2016; James, Brown, & Wilson, 2017; James, Jackson, & Jim, 2017; James & Magpantay, 2017; James & Salcedo, 2017). Participants of color shared experiences of mistreatment and exclusion that were much more pronounced than white participants:

When I was in the hospital, I watched a bunch of other white people coming in after me and get treated.... Also, my placement.... I didn't have a room or any curtains or anything. I had to watch white people come in and get taken to rooms and areas with curtains and watch doctors go by and get medicine for folks. I could watch doctors go by [and address a white patient] with a very enthusiastic voice.

While white trans people still received subpar treatment they did not face the same level of mistreatment experienced by trans and gender diverse POC. Living in the U.S. South also presents its own unique challenges to trans and gender diverse people's access to healthcare. Factors like higher poverty rates, lack of

structural resources, and high religiosity are some of the additional barriers that trans and gender diverse people face when trying to access healthcare in the South. One participant who helped organize in their state for trans resources explained:

It's so dated down here We're still having to fight with the church to get the resources that queer and trans folk need [My organization was] on a call where [the other organizers] kept pushing [for us to connect with the church] And, I'm like, but what if you're not welcomed in those [spaces]? How are we supposed to have access to stuff like that when we're not even welcome or invited in?

Finally, rurality creates its own unique barriers to healthcare for trans people (Knutson, Martyr, Mitchell, Arthur, & Koch, 2018). Many participants were unable to find a primary healthcare provider willing to treat them among the few providers practicing in their small local community. In rural areas, there was often one provider treating trans and gender diverse people across several counties. One participant spoke of these difficulties:

In my job [as a health insurance navigator], I cover a lot of rural areas. Some of these people that I meet with don't even know they qualify for healthcare, or that there are certain places they can go to [receive healthcare]. Since [the government] did cuts to Medicaid, a lot of rural clinics have been closing We're seeing more and more of our people having to come out and come into the city to do stuff. So, with that in mind, you gotta think about [queer and trans] people that we run into [in] these rural areas.

This participant went on to explain that for many trans people this means settling for basic healthcare and ignoring their desire to physically transition in order to receive healthcare.

Discussion

This study answers the call to address the understudied population of LGBTQ Southerners (Stone, 2018). Specifically, this study uses semi-structured focus group interviews to better understand the unique experiences of seeking and receiving healthcare as a trans and gender diverse person in the U.S. Southeast. We identified multiple barriers to care for trans and gender diverse Southerners: (1) fear and mistrust of providers; (2) inconsistency in access to healthcare;

(3) disrespect from providers; and, (4) mistreatment due to intersecting experiences of gender, race, class, and location. Overall, our findings offer evidence that trans and gender diverse Southerners are being excluded from healthcare services due to difficulties identifying providers willing to treat them and being regularly denied access by providers who lack the comfort and education in working with trans and gender diverse patients. When participants are able to find a physician, they often contend with an administrative and clinical staff that is less educated, aware, and/or welcoming of trans and gender diverse people. Too often, trans people are forced to accept mistreatment in the form of misgendering and harassment rather than risk access to healthcare altogether. This bargain of trading dignity and respect for quality healthcare was common among participants and often lead to fear and mistrust of medical providers.

While this study offers important insight into the healthcare experiences of trans and gender diverse Southerners, the study is not without limitations. First, convenience sampling presents challenges to diversity within the participant pool. Second, given the qualitative nature of the data, the results of this study should not be understood as generalizable to all trans and gender diverse Southerners. Rather, the function of this study is to begin to understand the healthcare experiences of trans and gender diverse Southerners so that better interventions may be developed to serve their needs. Finally, while our sample represents a diverse array of trans and gender diverse Southerners, it is limited in its scope of racial diversity. Future research should be more inclusive of Latinx trans and gender diverse Southerners.

Providers, practices, and healthcare systems across the Southeastern U.S. need to be mindful of trans and gender diverse patients under their care or searching for healthcare in their local communities. Providers should recognize that trans and gender diverse people exist in every community, are disproportionately disadvantaged within the healthcare system, and should be centered in efforts to provide the highest standard of care available. Future research should investigate

best practices for providing quality and affirming healthcare for trans and gender diverse patients.

Disclosure statement

No potential conflict of interest was reported by the authors.

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