SHORT REPORT

Transgender and Gender Nonconforming Patient Experience in the Inland Empire, California

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Abstract

Analyzing secondary data from a 2015 survey of 90 transgender and gender nonconforming individuals in California's Inland Empire, this study reports frequencies of physical and mental health and health care access and discrimination outcomes and differences by age, race/ethnicity, and sex assigned at birth. Nearly three-quarters of respondents reported positive physical health, yet only about half reported positive mental health—an outcome poorer for respondents <50 years. Lesser than 50% found it very easy to find providers for routine care and only 16% found it very easy to find a transgender-competent provider, underscoring the need for more health professional training.

Keywords: discrimination; health care access; mental health; physical health; transgender

Introduction

Transgender and gender nonconforming (TGNC) individuals face well-documented experiences of stigma, discrimination, and victimization, which are linked to adverse health outcomes and elevated levels of psychological distress.^{1,2} Although TGNC individuals need access to routine physical and mental health care and, often, gender-affirming treatments, they experience high rates of exclusion and discrimination in mainstream health care settings and barriers to accessing TGNC-competent care.^{3,4}

Although a growing body of research has documented physical and mental health outcomes and barriers to care among TGNC populations,^{1–4} local data collection remains key to identifying issues affecting the TGNC community in specific regions, ensuring the fair distribution of public health resources, and developing accessible health services.⁵ This study examines physical health, mental health, health care access, and health care discrimination among TGNC individuals in California's Inland Empire.

Consisting of Riverside and San Bernardino counties, the Inland Empire spans >27,000 square miles (~70,000 square kilometers) and has a population of nearly 4.5 million—exceeding that of 25 U.S. states.⁶

Assuming ~0.6% of the U.S. population is transgender,⁷ an estimated 27,000 TGNC individuals live in the Inland Empire, making it a critical region for assessing TGNC health care needs. The area is highly racially and ethnically diverse, with >50% of the population identifying as Hispanic, >7% as Asian, and >7% as black,⁶ which may make it comparable with other racial-ethnically diverse U.S. regions. Few regions of this size have undertaken similar studies to understand the health and wellness of transgender and gender-nonconforming people in racial-ethnically diverse settings.

Methods

Data set and sample

Secondary data were obtained from Riverside University Health System—Public Health, who collaborated with local transgender community groups to administer a survey as part of a comprehensive TGNC needs assessment. Initial findings were published as a community report (*Inland Empire Transgender Health and Wellness Profile, 2015*).⁸ The original survey was exempt from institutional review and the secondary data did not contain any identifying information about the research participants. Survey questions assessing demographics, self-identity, physical health, mental health, health care

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access, and discrimination were developed using the National Transgender Discrimination Survey and California Health Interview Survey as templates,^{9,10} and refined using feedback from community partners.

One hundred forty participants were recruited through website, Facebook, e-mail, posters in the community, and local newspaper advertisements, and completed the survey in May–August 2015. Among these, we excluded 27 respondents who did not reside in the Inland Empire, 21 who identified as cis-gender (gender-conforming), and 2 who did not complete the survey. The remaining 90 respondents resided in California's Inland Empire and identified as TGNC, constituting our analytic sample. Participants did not receive payment for completing the survey.

Measures

Physical and mental health. The survey assessed self-rated physical and mental health separately, using two questions: "in general, how would you rate your overall..." (1) "physical health?" and (2) "mental or emotional health?" We coded responses dichotomously as "positive" (for respondents reporting "good," "very good," or "excellent" health) versus negative (for respondents reporting "poor" or "fair" health). Additional questions included report of having a chronic physical health condition (asthma, high blood pressure, high cholesterol, diabetes, or cancer), depression or an anxiety disorder, or ever seriously considered suicide.

Health care access and discrimination. Health care access was assessed by asking respondents how easy it was to find a physician or mental health professional in their area who (1) "is willing to provide routine care?," (2) "has sufficient knowledge and experience on issues related to transgender people?," and (3) "is willing to provide hormone therapy?." We coded responses dichotomously as "very easy" versus "not very easy." Respondents also reported the degree to which they agreed "not enough health professionals are adequately trained to care for people who are transgender," which we coded dichotomously as "agree" versus "not agree."

Additional questions assessed whether respondents had health insurance, experienced monetary barriers to health care, or had disclosed their TGNC status to their health care providers. Health care discrimination was assessed by report of whether or not a health care professional refused to touch them or used excessive precautions because they were transgender, and whether the respondent was verbally harassed or disre-

spected, denied equal treatment, or denied service in a doctor's office or hospital.

Demographic variables. Binary variables were used for respondent's age (<50 years old vs. ≥50 years old), race/ethnicity (non-Hispanic white vs. Hispanic and/or racial minority), and sex assigned at birth (male vs. female).

Analyses

We calculated percentages and frequencies for all physical and mental health and health care access and discrimination outcomes. We then computed crosstabs and chi-square tests for each outcome, to test for significant differences by age, race/ethnicity, and sex assigned at birth. We performed all analyses using SPSS Version 25.0.

Results

Nearly all of the 90 participants in our sample were ≥18 years (97.8%, *n*=88) and highly educated: 45.6% (*n*=41) possessed a college degree and 42.2% (*n*=38) had completed some college. The most common terms that respondents used to describe their gender identity included transgender (46.7%, *n*=42), female to male/transgender man (30.0%, *n*=27), male to female/transgender woman (26.7%, *n*=24), gender nonconforming or gender variant (27.8%,

Table 1. Demographic Characteristics of Sample (*N*=90)

Variable	<i>n</i>	%
Age		
<50 years	71	78.9
≥50 years	19	21.1
Sex assigned at birth		
Female	50	55.6
Male	40	44.4
Race/ethnicity		
Non-Hispanic white	58	64.4
Hispanic and/or nonwhite	32	35.6
Gender identity ^a		
FTM/transgender man	27	30.0
MTF/transgender woman	24	26.7
Genderqueer	23	25.6
Gender nonconforming or gender variant	25	27.8
Transgender	42	46.7
Transsexual	10	11.1
Two-spirit	9	10.0
Feminine male	7	7.8
Other	21	23.3

^aPercentages do not add up to 100 because respondents could select multiple terms to describe their gender identity. To protect the confidentiality of respondents, we do not report the *n*'s or %'s for a small number of respondents (*n*<5) who indicated they identified as "masculine female or butch," "cross-dresser," and/or "drag queen/king."

FTM, female to male; MTF, male to female.

$n=25$), and genderqueer (25.6%, $n=23$). Table 1 reports the breakdown of our sample by all self-described gender identity categories and the demographic variables used to identify significant differences in outcomes.

Physical and mental health

The majority (74.4%, $n=67$) of respondents reported positive self-rated physical health, despite several respondents also reporting chronic conditions, including asthma (35.6%, $n=32$), high cholesterol (32.2%, $n=29$), high blood pressure (25.6%, $n=23$), diabetes (6.7%, $n=6$), and cancer (6.7%, $n=6$). Self-rated physical health did not significantly differ by age, race/ethnicity, or sex assigned at birth.

Approximately half (51.1%, $n=46$) of the respondents reported positive self-rated mental health, which differed only by age ($p=0.027$). 45.1% ($n=32$) of respondents <50 years reported positive mental health versus 73.7% ($n=14$) of respondents ≥ 50 years. A larger percentage of respondents reported having depression or an anxiety disorder (67.8%, $n=61$) or having ever seriously considered suicide (74.4%, $n=67$).

Health care access and discrimination

Despite the vast majority (93.3%, $n=84$) having health insurance, 43.3% ($n=39$) of respondents reported monetary barriers to health care in the past 12 months, which were more common among Hispanic and/or racial minority (62.5%, $n=20$) versus non-Hispanic white (34.5%, $n=19$; $p=0.011$) respondents and respondents <50 years (52.9%, $n=37$) versus ≥ 50 years (11.8%, $n=2$; $p=0.002$). 54.4% ($n=49$) of respondents reported having disclosed their TGNC identity to a health care provider, with differences seen by race/ethnicity: 63.8% ($n=37$) of non-Hispanic white versus 37.5% ($n=12$) of Hispanic and/or racial minority respondents had disclosed their TGNC status ($p=0.017$).

Less than half of all respondents reported it was very easy to find a physician (48.9%, $n=44$) or mental health care professional (36.7%, $n=33$) willing to provide routine care, with younger respondents reporting more difficulty: 45.6% ($n=31$) <50 years versus 76.5% ≥ 50 years ($n=13$) found it very easy to find a physician ($p=0.023$), whereas 33.8% ($n=23$) of respondents <50 years versus 66.7% ($n=10$) ≥ 50 years found it very easy to find a mental health care professional ($p=0.019$).

In contrast, only 15.6% ($n=14$) reported it was very easy to find a provider with sufficient knowledge and experience on issues related to transgender people, with differences identified by age and sex assigned at

birth. 8.7% ($n=4$) assigned female at birth versus 29.4% ($n=10$) assigned male at birth ($p=0.016$) and 13.4% ($n=9$) <50 years versus 38.5% ($n=5$) ≥ 50 years ($p=0.03$) found it very easy.

Of those taking or wanting to take hormone therapy ($n=50$), 34.0% ($n=17$) found it very easy to find a doctor willing to provide hormone therapy, and this did not differ by demographic characteristics. In addition, more than three-quarters (76.7%, $n=69$) of the total sample agreed there are “not enough health professionals adequately trained to care for people who are transgender,” with those <50 years (90.9%, $n=60$) more likely to agree than those ≥ 50 years (52.9%, $n=9$; $p<0.001$).

In terms of discrimination, 18.9% ($n=17$) of respondents indicated that health care professionals refused to touch them or used excessive precautions, and this was more common among respondents assigned male at birth (31.4%, $n=11$) than respondents assigned female at birth (12.2%, $n=6$; $p=0.031$). At the doctor's office or hospital, 21.1% ($n=19$) of respondents reported being verbally harassed or disrespected, 10.0% ($n=9$) reported being denied equal treatment, and 6.7% ($n=6$) reported being denied service. These outcomes did not differ by demographic characteristics.

Discussion

To our knowledge, this is the first time TGNC individuals' health outcomes and health care access has been assessed in California's Inland Empire, adding to the limited existing literature on TGNC health. Despite recent advances in TGNC visibility and equality,¹¹ our results suggest that the Inland Empire's TGNC population continue to face significant health challenges and barriers to accessing TGNC-competent care.

Although nearly three-quarters of our sample reported being in positive physical health, chronic conditions requiring regular monitoring and/or treatment were prevalent among our respondents. Echoing previous studies that have identified high rates of psychological distress within TGNC populations,^{1,2} it is especially concerning that only about half of our sample reported positive mental health—an outcome worse for TGNC individuals <50 years. Further highlighting mental health as a key concern, the majority of respondents reported having depression or an anxiety disorder and/or suicidal thoughts.

Potentially exacerbating physical and mental health concerns among TGNC individuals, our study identified a lack of access to TGNC-competent health care. Less than half of our sample found it very easy to find a physical or mental health provider for routine care,

only one in six found it very easy to find a provider with TGNC competency, and—similar to findings from assessments in other geographic regions^{12–14}—one in five had experienced discrimination in health care settings.

Hispanic and/or racial minority TGNC individuals faced increased monetary barriers to care and were less likely to disclose their TGNC identity to providers. Accessing TGNC-competent providers was also more challenging for younger TGNC individuals and those assigned male at birth—the latter whom were also more likely experience discrimination in health care settings. In order for TGNC individuals with physical or mental health concerns to receive appropriate care, health providers and their medical staff must gain more knowledge of and experience with issues relevant to the diverse TGNC community and ensure that their services are easily identifiable and accessible.³

Although we identify important areas for the improvement of health services for the Inland Empire's TGNC population, this study has some limitations. Although the validity of self-rated health is well established,¹⁵ the presence of specific medical conditions are likely underreported by respondents because they have yet to receive a formal diagnosis.

Our sample also represents only a small portion of the total estimated TGNC population in the Inland Empire. Although the Inland Empire is racially and ethnically diverse, our sample was disproportionately non-Hispanic white. Hispanic or racial minority TGNC people may experience both transphobia and racism that leads to poorer health care access and health outcomes.¹⁶ The majority of our sample also had health insurance and at least some college education; hence, homeless, unemployed, and low-educated TGNC individuals—who typically face additional barriers to care^{17,18}—are underrepresented. Future studies should assess the experiences and needs of these diverse racial-ethnic and socioeconomic subgroups within the TGNC population.

Overall, this study highlights the critical need for TGNC competency among health professionals in California's Inland Empire, and services that are inclusive and accessible to TGNC individuals regardless of age, race/ethnicity, or sex assigned at birth. Although medical schools need to better integrate TGNC-competency into their curricula to better prepare future generations of health providers,¹⁹ practicing health providers can do more to create TGNC-affirming and inclusive environments by enrolling themselves and their staff in transgender-specific

training programs, using patients' chosen pronouns, and creating a welcoming clinic environment (e.g., with inclusive restroom policies).²⁰ Future studies of the Inland Empire and other geographic regions should further assess TGNC needs within medical specialties, such as obstetrics/gynecology, urology, and endocrinology.

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Abbreviations Used

FTM = female to male
MTF = male to female
TGNC = transgender and gender nonconforming