Transgender Patient Perceptions of Stigma in Health Care Contexts

Kami Kosenko, PhD, Lance Rintamaki, PhD,† Stephanie Raney, BA,* and Kathleen Maness, BA**

Objectives: Transgender individuals, or those who cross or transcend sex categories, commonly experience stigma and discrimination. Anecdotal evidence indicates that this transphobia manifests in health care settings, but few studies address the forms of mistreatment experienced in this context. This study was designed to explore transgender patients' experiences with health care. This brief report focuses on their negative experiences.

Methods: A total of 152 transgender adults were recruited to complete an online questionnaire about their health care. Participants were asked if and how they had been mistreated, and responses were analyzed by qualitative content analysis.

Results: Participants' descriptions of mistreatment coalesced around 6 themes: gender insensitivity, displays of discomfort, denied services, substandard care, verbal abuse, and forced care.

Conclusions: These findings provide insight into transgender patients' perceptions of and sensitivity to mistreatment in health care contexts. This information might be used to increase providers' cultural competency and inform their interactions with transgender patients.

Key Words: transgender, stigma, health care

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Transgender refers to those who experience profound discomfort with their natal sex.[1] This umbrella term covers a range of gender-variant individuals, including transsexuals, cross-dressers, and genderqueer individuals.[2] Although the exact size of this community is unknown and perhaps unknowable,[3] much is known about the challenges experienced by community members. Transgender individuals face social sanctions, including violence and discrimination, for violating prescribed gender norms (blinded). The stigma and isolation they experience heightens their risk for mental health problems, such as depression, anxiety, posttraumatic stress disorder, and substance abuse.[4–7]

Despite these health concerns, some transgender individuals hesitate to seek care for fear of being mistreated by health care providers.[8] Although few studies focus specifically on this issue, several mention problematic interactions with providers and their negative impact on transgender patients. For example, in an HIV-risk assessment of transgender youth, Garofalo et al[9] noted that 20% of the sample had experienced mistreatment at the hands of medical and social service providers. Focus groups with transgender individuals have brought to light discriminatory practices in HIV/AIDS care facilities,[10] and substance abuse treatment programs have been described as unwelcoming to transgender clientele.[11]

Participants in these and other studies[12] report discriminatory and insensitive treatment from some health care providers, yet little is known about the specific provider behaviors deemed problematic. As such, we have limited knowledge of what constitutes culturally sensitive and insensitive care for these patients. The need for such research is underscored by findings from studies of lesbian and HIV patient perceptions of medical mistreatment. These studies[13,14] indicate that members of stigmatized groups might interpret even well-intended provider behaviors as stigmatizing and discriminatory. Negative patient perceptions of such behaviors, regardless of provider intent, will breed discomfort with and distrust of medical professionals and, ultimately, discourage transgender individuals from seeking care.[2,15] This lacuna also hinders the efforts to develop culturally relevant health care resources for transgender patients and training programs for health professionals, as recommended by the American Public Health Association. In 1999, the American Public Health Association issued a statement, urging health professionals "to be sensitive to the lives of transgendered individuals and treat them with dignity and respect." The statement, however, does not provide specific information regarding the kinds of behaviors that are deemed problematic by transgender patients and, thus, should be avoided by health professionals.[2] To this end, we designed a study focused on transgender patients' experiences in health care contexts. This brief report centers on participants' negative experiences.

METHODS

The data for this study were collected in 2010 as part of an IRB-approved needs assessment of transgender adults. Self-identified transgender individuals were recruited to complete a questionnaire about their health care experiences (both positive and negative) through links posted online as well as by mailings to lesbian, gay, bisexual, and transgender organizations across the United States. The questionnaire

From the *Department of Communication, North Carolina State University, NC; and †Department of Communication, State University of New York, Buffalo, NY.

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Reprints: Kami Kosenko, PhD, Department of Communication, North Carolina State University, 201 Winston Hall, P.O. Box 8104, Raleigh, NC 27595. E-mail: kakosenk@ncsu.edu.

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began with a consent form and demographic questions. After a series of questions about their positive health care experiences, participants were asked, "Have you ever experienced mistreatment in health care settings because of your gender identity or presentation?" Affirmative responses led to a set of open-ended questions in which participants were asked to describe a specific instance of mistreatment. Next, they were asked if they had a second instance to report, and those who did completed the same set of questions again. After submitting their responses, participants were given the opportunity to provide contact information and enter a raffle.

Data were collected and analyzed in keeping with Morse and Field's[16] conventional qualitative content analytic approach. For example, we collected and analyzed data simultaneously, which allowed us to identify emerging themes and assess theoretical saturation.[17] Data analysis was aided by 2 coders with training in qualitative content analysis and experience with the transgender community. First, each coder independently reviewed the entire set of participant responses to identify key themes and ideas. Then, we reconvened to compare and discuss our respective findings, settling disagreements through group discussion. Together, we assembled a list of key ideas, grouped similar ideas into categories, and developed category labels. The result was a categorical system describing the problematic provider behaviors encountered by participants. We then returned to the data to independently assess the system's exhaustiveness. We met once more to discuss necessary revisions, to identify data segments that exemplified each category, and to count the total number of data segments in each category.

RESULTS

The sample consisted of 152 self-identified transgender[2] adults from 40 different states and 2 foreign countries. Table 1 includes additional information about the sample. When prompted, 71% of the sample reported at least 1 instance of mistreatment in health care contexts, and 23% chose to describe >1 instance. Participants recounted negative interactions with various health professionals, including doctors, nurses, and emergency medical technicians, and framed particular provider behaviors as problematic: (1) gender insensitivity; (2) displays of discomfort; (3) denial of services; (4) substandard care; (5) verbal abuse; and (6) forced care. These perceived problematic provider behaviors (PPPBs) and their relative frequencies in the dataset are detailed in Table 2 and described more fully below, beginning with the most frequently occurring PPPB.

TABLE 2. Emergent Themes, Frequencies, and Representative Quotations

Problematic Health Care Interactions	Frequency, N (%)	Representative Quotations
Sex insensitivity	45 (31.46)	"At one hospital, I was made to wear a pink floral hospital gown, and incorrect pronouns were used even after I explained that I'm male."
Displays of discomfort	41 (28.67)	"I was having a physical exam, and the doctor simply seemed very uncomfortable around me. She didn't really look at me when she was talking to me. The overall feeling I got was one of extreme discomfort, and I didn't really feel safe there."
Denial of services	30 (20.97)	"When I explained to him [a physician] that I was transgender and hoped to become a woman soon, he told me to leave the office!"
Substandard care	10 (6.99)	"Mistakes were made on all of my medical records. My partner, who also looks gender variant, didn't receive anesthesia for 36 stitches. They stitched her wrong and had to re-do it. They didn't give my partner antibiotics, and her head wound got severely infected. Her doctor asked if she had stitched it herself because it looked that bad."
Verbal abuse	10 (6.99)	"After pouring my heart out for almost an hour to a mental health therapist, she looked at me and said, 'I don't blame your family for disowning you. If I were your friend, I wouldn't have anything to do with you either.'"
Forced care	7 (4.89)	"A psychologist misdiagnosed me. She decided that I was a hermaphrodite and told me if I didn't go to a mental health center that she would send the police to make me go."

TABLE 1. Participant Characteristics: Sex Identity, Employment, and Health Insurance Status

Sex Identity: No. Participants (%)					
Transsexual	Genderqueer	Cross-Dresser	Intersex	Androgynous	Third Sex
90 (59.2)	22 (14.5)	14 (9.2)	10 (6.6)	10 (6.6)	6 (3.9)

Employment: No. Participants (%)						
Full-Time	Part-Time	Self-Employed	Student	Unemployed	Disability	Retired
46 (30.3)	27 (17.8)	11 (7.1)	32 (21.1)	17 (11.2)	10 (6.6)	9 (5.9)

Health Insurance: No. (%) Participants (%)		
Yes	No	Don't Know
121 (79.6)	2 (1.3)	29 (19.1)

N = 152; mean age, 39.1 y; SD, 15.6 y; range, 18–74 y.

Gender Insensitivity

Many participants perceived providers as insensitive to gender identity and related concerns. Using incorrect pronouns (eg, using "he" in reference to a trans-woman), poorly wording questions and comments about the patient's gender identity (eg, telling a trans-man that he's "not a real man"), commenting on how well the patient was passing (eg, "You're really a man? You fooled me!"), and/or attempting to dissuade the patient from transitioning were all deemed insensitive and problematic.

Displays of Discomfort

Many participants described a heightened sensitivity to awkward interactions with providers. This heightened sensitivity led transgender patients to interpret ambiguous provider behaviors, such as fidgeting, staring, or avoiding eye contact, as stigmatizing and discriminatory. Although these provider behaviors could be the result of any number of factors, and might not be indicative of provider prejudice, participants believed that these behavioral cues signaled a provider's discomfort with and negative feelings toward transgender patients.

Denial of Services

One in 5 problematic interactions reported by participants involved health professionals refusing to care for transgender patients. This included the providers' denial of desired medical treatments (eg, hormone treatments or referrals for gender reassignment) and their refusal to meet or make appointments with transgender patients.

Substandard Care

Other participants indicated that, although they were not denied services, they were not given quality care. When providers were rough during examinations, did not respond to cries for help, and/or kept patients waiting for extended periods, transgender patients believed that they were being mistreated and given substandard care.

Verbal Abuse

Participants also described instances in which they were mocked, belittled, and otherwise verbally abused by health professionals. Name-calling, swearing, and making threats and insulting comments were among the offenses.

Forced Care

Finally, 7 participants reported being forced to undergo procedures and treatments. When participants disclosed their transgender status, some were committed to psychiatric institutions, and others were subjected to what they thought were unnecessary examinations. Although few providers went as far as to commit their patients, some seemed to dismiss transgender patients and their concerns as "psych cases."

DISCUSSION

Prior research[8–11] noted that transgender individuals experienced mistreatment in health care settings but offered little information about its forms or effects. Study participants indicated that they experienced medical mistreatment in various forms, which ranged from being denied services and/or quality care to being committed to psychiatric facilities due to their transgender status. Other participants described providers who seemed uncomfortable in their presence or insensitive to gender identity and related concerns. These PPPBs ranged from subtle and ambiguous (eg, avoiding eye contact) to blatant and inflammatory (eg, calling the patient a "freak"). These findings and their implications for research and practice are described more fully below.

First, it is important to note that, although participants attributed these negative experiences to transphobia, other factors could account for the PPPBs identified in this study. For example, a provider's awkwardness might not be symptomatic of transphobia; participants, however, attributed these and other ambiguous behaviors to stigma. Attribution theories and research help explain these findings. According to attribution theory,[18] individuals explain their own behavior and the actions of others as either internally or externally motivated. Attributional ambiguity theory[19] indicates that stigmatized individuals might attribute others' actions to a third factor—stigma. Research indicates that stigma attributions offer some protection against threats to self-esteem but only in situations involving blatant discrimination.[20] The more subtle the discrimination, the less self-protection stigma attributions afford.[21] Experiencing more overt forms of discrimination and attributing it as such could buttress self-esteem in transpatients, but those who experience subtle prejudice and make stigma attributions might not reap the same benefits. Given the potential consequences of stigma attributions, additional research on transgender patient experiences with and attributions of stigma in health contexts seems warranted.

These data cannot speak to provider intentions (see Snelgrove et al[22] for the provider's perspective). Even so, this study offers examples of behaviors that might be misinterpreted and, thus, should be avoided when working with transgender individuals. As such, these findings can be used to inform the development of cultural competency programs for providers. Groups, such as the American Medical Association and the American Psychiatric Association,[23] have called for changes in medical school curricula and the medical licensure process to facilitate provider training and assessment in lesbian, gay, bisexual, and transgender health. Findings from this study suggest the need to extend these same recommendations to preparatory programs for others involved in direct patient care. These findings also provide support for arguments made by those within and outside of the medical field about the importance of communication education for providers. Despite ample evidence of the effects of provider communication on patient satisfaction, adherence, clinical outcomes, and malpractice claims,[24] most medical schools devote little time and attention to communication. Moreover, continuing education programs tend to focus on the biomedical aspects of patient care and offer few opportunities for providers to further their communication education or hone their communication skills.[25] Increasing educational opportunities for providers and the time and attention given to communication in existing training programs is necessary to improve the quality of care received by patients, in general, and transgender individuals, in particular.

These findings also have implications for the ongoing debate about the inclusion of gender identity disorder (GID)

in the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV).[26] Transgender advocates claim that this diagnostic label pathologizes gender variance and worry that its inclusion in the DSM gives credence to the idea that transgender individuals can be "cured"[27]; whereas, others caution that removing GID from the DSM could negatively impact insurance coverage and access to care.[28] Our findings suggest that some providers might pathologize transgender patients, forcing them into psychiatric facilities and treating them as "psych cases." At the very least, these actions point to problems with how gender identity issues are understood and treated. With the DSM-V currently in development,[26] continued discussions of GID and the potential consequences of its inclusion in or removal from the manual are warranted.

Study limitations also warrant consideration. Limitations include the use of nonprobability sampling techniques, which limit generalizability, and our failure to assess when each instance of mistreatment occurred. Probability sampling is made difficult by the lack of reliable population estimates and the hidden nature of the transgender community.[29] These restrictions underscore the necessity of developing and using innovative recruitment strategies and sophisticated sampling designs when working with this population. Not asking participants when the reported instances of mistreatment occurred meant that we could not assess behavioral trends. Additional qualitative and quantitative research is needed to determine if, why, and how provider behavior towards transgender patients has changed over time and to identify antecedents to and consequences of PPPBs. Despite its limitations, this study gave voice to a group who has been historically marginalized and silenced. This study also produced specific examples of provider behaviors perceived as insensitive by transgender patients. We hope these examples offer providers further guidance with respect to specific behaviors to avoid when interacting with individuals who identify as transgender.

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