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Diverse and Resilient: Insights into the Demography, Quality of Life, and Gender-Related Life Experiences of Transgender Wisconsin Residents

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DIVERSE AND RESILIENT: INSIGHTS INTO THE DEMOGRAPHY, QUALITY OF LIFE,
AND GENDER-RELATED LIFE EXPERIENCES OF TRANSGENDER WISCONSIN
RESIDENTS

By

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A Professional Project submitted to the Faculty of the Graduate School,
Marquette University,
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Milwaukee, Wisconsin

May 2014

ABSTRACT
DIVERSE AND RESILIENT: INSIGHTS INTO THE DEMOGRAPHY, QUALITY OF LIFE,
AND GENDER-RELATED LIFE EXPERIENCES OF TRANSGENDER WISCONSIN
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Claire Van Fossen, B.A.

Marquette University, 2014

The purpose of this study was to describe the demography, quality of life, and gender-related life experiences of Wisconsin's transgender residents. For this mixed-methods pilot study, a snowball sampling technique was used to recruit transgender Wisconsin residents (n=29) to complete an anonymous online survey that included demographic measures, quality of life measures, and free response questions on experiences related to respondents' gender in specific contexts. The original survey instrument was modeled on similar reliability and validity-tested instruments and was field-tested before being used. Descriptive analysis was used to interpret demographic and quality of life data and thematic content analysis was used to interpret qualitative data on gender-related life experiences.

The sample was diverse in terms of demography. The average participant was 18-30 years of age, white, prescribed a sex of female at birth, transgender, queer, and partnered. Quality of life among the sample was lower than among the U.S. population. The rate of homelessness was higher than the national average and unemployment was more than twice the national rate. On average, participants were in good health, of low-middle income, and more educated than the average American. While a history of mental health issues was prevalent, respondents reported being in average to good mental health. Human Immunodeficiency Virus (HIV) status was overwhelmingly negative and sexual risk behaviors were low. Incidence of negative gender-related experiences was high within the contexts of healthcare and education and 63% of respondents reported having been harassed because of their trans* identity.

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Claire Van Fossen, B.A.

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Diverse and Resilient: Insights into the Demography, Quality of Life, and Gender-Related Life Experiences of Transgender Wisconsin Residents

Background & rationale of the study. Transgender persons make up an estimated 2 to 5% of the population (Transgender Law and Policy Institute, 2013). Little research on transgenderism exists, and virtually no literature on the demography, quality of life, or experiences of transgender persons living in the Midwest exists. This research study aims to increase the body of knowledge on the experiences of transgender individuals in a specific Midwestern state, with special regard for the complex intersections of identity of such persons. Specifically, the goal of the study was to provide insight into the demography, quality of life, and gender-related experiences of transgender residents of Wisconsin with consideration of the role of intersections of identity and locale in those experiences. The investigator utilizes queer theory and pragmatic theoretical approaches, as the goal of the research is to practically inform the establishment and improvement of services for the transgender population as well as identify potential solutions to the key social issues they face. Finally, the research seeks to deconstruct the power relationships that disadvantage and disenfranchise the transgender population of Wisconsin.

This study involved recruiting as many transgender individuals from Wisconsin as possible between August and December of 2013 to participate in an anonymous, online, investigator-developed, 21-question survey. The investigator-designed survey instrument included information related to demographics, quality of life, and discrimination experiences of residents of Wisconsin who identify as transgender. A mixed-methods approach was used. The survey instrument was modeled on similar, validity and reliability tested instruments utilized for collecting similar data. Specifically, the quality of life section was modeled on a valid,

accessible, and clinically relevant tool for assessing the quality of life in a population called the Short Form 36-Item Questionnaire version 2 (SF36v2). The survey instrument was field-tested before being used. Descriptive analysis was used to interpret demographic data and Likert-scaled quality of life data. Thematic content analysis was used to interpret free response quality of life data as well as data about participants' gender-related life experiences. The findings were credibility tested with multiple trans* Wisconsinites and a gender researcher. With a larger sample, analysis of association would also have been conducted to study the relationships between certain quality of life indicators and demographics of the sample.

Terms and definitions. Gender and sexuality, as well as the terms and concepts associated with them, are constantly evolving. New terminology is continuously emerging, as gender and sexuality nonconforming individuals and groups develop and change in terms of self-identity and communal identity. As such, there are myriad terms and definitions specific to gender studies and gender and sexuality-related research that are relevant to this study, and for reader ease, are identified in Table 1. Those terms most commonly used in this research are described more in depth and extrapolated upon below. Of note is the fact that the primary investigator of this study employs the gender-neutral pronoun “their” in place of “his” or “her” throughout this article, as a practice in queer theory.

Table 1

Terms and Definitions by Category

Category	Term	Definition
<i>Sexual Identity:</i>	Sexual Identity	A person's sexual identity is the innate trait which inclines one to be sexually, emotionally, or romantically attracted (or all of these) to people of a particular sex or gender (Johns Hopkins University, 2013).
	Pansexual	Also called omnisexuality, pansexuality is sexual, romantic, or emotional attraction to people of all gender identities and biological sexes; indeed, pansexuality even encompasses the

		concept that gender and sex are insignificant or irrelevant in determining whether they will be sexually attracted to others ((Johns Hopkins University, 2013).
	Queer	Queer is an umbrella term for sexual (and gender) minorities (people whose sexual identity falls outside the norm or differs from the majority of surrounding society). The term challenges categorical and binary approaches to gender and sexuality and is a reclaimed pejorative term (meaning strange or peculiar) used to describe homosexuals in the late 19 th century. Because of this history, it should only be used as a self-identifying term by self-identified queer persons (Johns Hopkins University, 2013).
Sex:	Sex	Sex is a term for the biological and physiological identity of humans (usually based on sex chromosomes, where two X chromosomes produce female sexual anatomy and an X and a Y chromosome produce male sexual anatomy). Hormone levels, secondary sex characteristics, and internal and external genitalia may also be considered criteria in the determination of one’s sex (Johns Hopkins University, 2013).
	Prescribed/ assigned sex	Sex assignment is the process, usually conducted by a doctor or parents, of discerning the sex of a child prior to or at the time of their birth. The process usually involves inspecting the external genitalia of a baby, and deeming it male or female. Often, parent parents rear their child as a member of the sex they are assigned at birth. Thus, one’s assigned or prescribed sex is the arguably arbitrary sex identity of male or female imposed upon children based on one anatomical trait which may not reflect their gender identity or even their biological or physiological identity at all (Johns Hopkins University, 2013).
	Intersex	The term intersex is used to describe individuals whose biological development is intermediate between male and female or persons who are born with chromosomes, genitalia, and/or secondary sexual characteristics that are inconsistent with the typical definition of a male or female body. It should be used in lieu of the scientifically inaccurate term “hermaphrodite” (Johns Hopkins University, 2013).
Gender Identities:	Gender Identity	Gender identity is an individual’s innate, internal sense of gender, which may or may not be the same as one’s gender assigned at birth. Some examples of gender identities are "woman," "transman" and "agender", but myriad more exist. Gender identity differs from but is often conflated with gender expression, which is how a person expresses their gender identity through clothing, behavior, mannerisms, speech, activities and more. Gender identity is also often conflated with sex, but they are separate concepts – please see the category “sex” for distinctions (University of California Berkeley,

		2012).
	Gender Queer	The term gender queer describes individuals who have a non-normative, non-conforming, or non-binary gender identity. It is a reclaimed derogative term for sometimes still used as a slur, and thus should only be used as a self-identifying term by self-identified gender-queer persons (University of California Berkeley, 2012).
	Third Gender	The term third gender is used to describe individuals who are categorized (by their will or by social consensus) outside the gender binary (i.e., as neither man nor woman), as well as to describe the social category present in those societies who recognize three or more genders (University of California Berkeley, 2012).
	Trans*	The term trans* (with an asterisk) is an umbrella used to describe individuals who identify as transgender and transsexual (the terms usually understood as included when the prefix trans is used on its own) as well as individuals who do not identify with the gender they were assigned at birth. This term utilizes the asterisk as a placeholder for suffixes of trans- such as *gender, *sexual,*feminine, *masculine, *folks, *person,*guy,*girl,*woman, or *man- but also to represent identities that do not start with the prefix “trans,” but can be understood as under the trans* umbrella. These identities include, but are not limited to, genderqueer, bigender, third gender, gender fluid, genderless, MtF, FtM, Two Spirit, non-binary, androgynous, and masculine of center (MOC), and myriad other perpetually emerging and evolving terms. While all of these identities are distinct from one other, each can be understood as under the trans* umbrella, because the individuals who self-identify by them do not identify as the gender they were assigned at birth and/or are “queering” (deviating from norms; blurring) gender expectations and assumptions (University of California Berkeley, 2012).
	Transgender	Transgender is the state of one's gender identity or gender expression not matching one's assigned sex (identification by others as male, female or intersex based on anatomical/physiological trait(s)). Transgender is an identity independent of sexual orientation. Transgender people may identify as heterosexual, homosexual, bisexual, pansexual, or myriad other sexual identities or may consider conventional sexual identity labels inadequate or inapplicable to them. The term transgender encompasses individuals whose identity does not conform unambiguously to conventional notions of male or female gender roles, but combines or moves between these; individuals who were assigned a sex, usually at birth and based on their genitals, but who feel that this is a false or incomplete

		description of themselves; and/or individuals who do not identify or present as the sex they were assigned at birth (University of California Berkeley, 2012).
	Transsexual	Transsexual is a word used to describe individuals whose gender identity is not congruent with or not culturally associated with their assigned sex or an individual whose assigned sex at birth conflicts with their gender identity (University of California Berkeley, 2012).
<i>Transitional Terminology:</i>	Transitional Terminology	Vernacular and jargon inherent and specific to the transgender community, used colloquially to refer to processes, realities, and concepts endemic to trans* persons.
	Female-to-male (FTM)	Someone who was female assigned at birth that now identifies as male (Stanford University, 2012).
	Male-to-female (MTF)	Someone who was male assigned at birth that now identifies as female (Stanford University, 2012).

The term “gender identity” describes an individual’s internal concept of his, her, or their gender – it is one’s inner sense of being male, female, genderqueer, third-gender, or otherwise between or outside of traditional gender norms (Garofalo et. al, 2006). Gender identity is independent of biological sex; gender and sex need not be and often are incongruent (Garofalo et. al, 2006). “Transgender” or “trans*” is a term that refers to individuals whose assigned gender is incongruent with their gender identity or gender expression (Garofalo et. al, 2006). This means they may have been assigned a gender at birth based on their external genitalia or biologic sex that is not true to who they are in terms of gender (Garofalo et. al, 2006). Trans* people may identify as the gender considered through a binary gender framework to be the opposite of the prescribed biologic sex, they may have developed an original gender-identity of their own, or they may identify simply as trans*. The term “transgender” does not necessarily indicate or imply transition from the prescribed biologic sex to a gender or sex considered to be in congruence with the “opposite” biologic sex. The term can also denote a person’s identity who

does not prescribe to a binary concept of gender and feels that neither “male” nor “female” designations are adequate or befitting to describe their gender identity.

The distinction and interaction between the terms “biologic sex” and “gender identity” is integral in defining and understanding transgenderedism (Garofalo et. al, 2006). “Biologic sex” is typically assigned at birth based upon characteristics of the external genitalia. Regarding the intersection of sex and gender, Garofalo et. al (2006) state, “Typically male (penis) or female (vulva), a binary model of biologic sex fails to consider the disconnection between anatomy, karyotype and phenotype in individuals with intersex conditions. *Gender*, however, is a more personal and culturally defined construct based upon one’s inner sense of being male or female. Gender occurs across a wide continuum and its complexity is not well captured as a binary construct. For transgender individuals, gender identity differs from biologically defined sex.” While transgenderism may manifest itself in some as a transsexual, transitional experience from one gender within the binary framework to the other, for others it may mean coming to identify outside the binary, such as by a third gender or as gender non-conforming or gender queer.

In addition to “gender identity” and “biological sex”, “sexual identity” also plays a role in understanding and defining transgender identity. “Sexual identity” is defined by the gender identity of persons to whom an individual is physically and/or emotionally attracted (Garofalo et. al, 2006). Transgender individuals may identify anywhere along the spectrum of sexual identity, including by terms such as heterosexual, homosexual, and queer, or terms of their own divining, such as genderqueer, bigender, gender fluid, Two Spirit, genderless, etc. Thus, there are many layers of identity that play a prominent role and require consideration in living or seeking to understand the transgender experience. This study aims to be inclusive of all those layers in order

to provide a holistic depiction of the demographics and experiences of transgender residents of Wisconsin.

For the purpose of this study, the term “gender-related life experiences” is defined as any occurrences or events respondents feel are related to or relevant to their lived experience as trans* persons. The survey instrument defined this term for respondents and asked them to share details about gender-related life experiences within employment, healthcare, personal network, and family contexts and also provided space for respondents to share any general or other gender-related life experiences they felt might be important or relevant. Moreover, “quality of life” is a term used to describe the level of functioning and perceived well-being of a population.

Finally, for the purpose of this study the term “sexual risk behavior” is sourced from the Center for Disease Control and Prevention and was defined for participants as unprotected sex with multiple partners, engagement in sex work, or unprotected sex with a single high-risk partner. A high-risk partner was defined as one who has multiple partners, is engaged in sex work, or injects or has injected drugs. Respondents were asked to disclose the frequency of their engagement in sexual risk behaviors, and this definition of that term was provided for respondents within the survey.

Theoretical frameworks. The primary investigator approached this research using queer theory and pragmatist theoretical frameworks. The first theoretical framework, queer theory, is applied in this study by virtue of the examination and critique of social and cultural paradigms around gender and sexuality inherent to the work. The queer theory approach is rooted in feminist critique and lesbian, gay, bisexual, and transgender (LGBT) studies and emerges from post-structural interest in fragmented, de-centered knowledge building, language, and psychoanalysis (Plummer, 2005). Queer theory as a theoretical lens focuses on gay, lesbian,

homosexual, and gender-nonconforming identities and how they are culturally and historically constituted, linked to discourse, and affirm or challenge social constructions of gender and sexuality (Plummer, 2005). Queer theory also explores the complexities of the construct, identity, and how identities reproduce and “perform” in social forums (Plummer, 2005).

A primary concern of queer theory is the manner in which gender and sexuality is discussed. Queer theory is interested in the breakdown of binaries such as male and female and seeks to understand, affirm, and illuminate the in-betweens of conventional identity labels and categories (Watson, 2005). Queer theory contests, challenges, and dismantles systemic and structural relationships of power that are historically tied to hetero and cisnormative attitudes, values, and practices, as well as hetero and cisnormative ideological, linguistic, existential, and strategic conventions and constructs (Grace, 2008). Implicit in the framework is the understanding that these power relationships have historically denigrated or dismissed sexes, sexualities, and genders not sanctioned by hetero and cisnormativity. Heteronormativity presumes and values heterosexuality (or the opposite-sex attraction between a biological XY male and a biological XX female) over other sexual and romantic manifestations and cisnormativity presumes and values biological XY maleness and biological XX femaleness and relationships between the two over other sex, gender, sexual, and romantic identities. Queer theory seeks to deconstruct that valuation and the assumptions and prejudices upon which it is based (Grace, 2008).

The second theoretical framework, pragmatism, is employed in this study by virtue of the investigator’s intention to apply the study’s findings in order to help augment transgender quality of life in Wisconsin. Pragmatism is a framework distinguished by its focus on useful knowledge and the application of knowledge in practice (Iaydjiev, 2012). It is a framework rather

unconcerned with metaphysical and theoretical musings, but instead with concepts and theories only insofar as they indicate, affect, and are relevant to practical consequences. Pragmatism places problems in their social and historical context in order to best achieve valuable end-causes and outcomes in practice and thus often employs multiple relevant forms of data collection to answer the research question(s). Pragmatism is firmly rooted in the empiricist and experiential schools of philosophy, “arguing against the metaphysical presumptions of rationalism and instead focusing on how humans adapt to their environments by incorporating new experiences during their practice, itself a starting point and terminus for knowledge” (Iaydjiev, 2012).

Pragmatism in social science research remains committed to finding solutions to problems in the real world by generating useful knowledge. Pragmatism is strongly linked to ontological realism, “which assumes a world independent from the observers, whereas the social world is characterized by intersubjectively shared understanding” (Iaydjiev, 2012). The framework also denounces the correspondence theory of truth as knowledge progressing us closer and closer to some ‘reality’ somewhere ‘out there.’ Rather, pragmatism stands for epistemological instrumentalism, derived from the view that theories are valuable only insofar as they are instruments that facilitate orientation and discernment in a complex social world, and for a consensus theory of knowledge by which knowledge is deemed valuable based on evaluation by both scholarly and external communities (Iaydjiev, 2012).

Research questions. One overarching question that framed the study was, “Who are the transgender residents of Wisconsin, what are their lived experiences related to gender, and how do they perceive their identity as being associated with their quality of life and experiences?”

Guiding research questions were as follows:

- Who makes up the transgender community of Wisconsin, demographically speaking?

- What is the quality of life of transgender residents of Wisconsin?
- How do trans* persons perceive the social perception of transgenderism, culture and environment, and social interactions as affecting their quality of life, if at all?
- What are the life experiences of transgender residents of Wisconsin, related to their gender, especially in areas of their lives that literature points to as being significant to the lived experience of transgender persons?

While there was no hypothesis for this study, the primary investigator was interested in comparing the findings with the findings of existing literature on the topic and expected the findings to mirror what the literature suggests with regard to the population, such as lack of access to compassionate, quality transgender healthcare; negative gender-related life experiences, like harassment, discrimination, and mistreatment, within educational, professional, and personal environments; and significant mental health challenges. The author's intention for the study is to publish and present on the findings, make targeted recommendations to improve the services available to transgender residents of Wisconsin, and utilize the findings to persuade key stakeholders to invest in and innovate around addressing key social issues facing transgender residents of Wisconsin.

Literature Review

Ten research studies were examined to explore the quality of life of diverse transgender individuals living in the United States. Existing qualitative literature indicates that diverse transgender persons face significant challenges in multiple contexts, including within their families, within the educational system, and within the healthcare system, to name a few (Newfield, 2006; McGuire, 2010; Reck, 2009; Kenagy, 2005). The research supported that

transgender individuals have a lower quality of life on average than both their lesbian, gay, bisexual and sexuality and gender majority counterparts (Kenagy 2005; Reck 2009; Garofalo et al., 2006; Newfield et al., 2006; McGuire et al., 2010). Transgender people of color, transgender youth, female transgender individuals, and lower-class transgender individuals communicated enduring a lower quality of life on average than white, adult, male, and middle and upper-class transgender individuals (Garofalo et al., 2006). Quality of life was lower still for individuals with any combination/intersection of oppressed/under-privileged identities (Reck, 2009).

The literature further suggested that transgender people dealt with high risk of HIV, unstable housing, economic difficulties, challenges accessing culturally competent and compassionate health care, limited familial support, and high rates of substance use and sexual risk behavior relative to the general population, especially transgender youth of color and male-to-female (MTF) youth (Wilson, 2009; Kenagy, 2005; Garofalo et al., 2006; Rachlin, 2008; Reck 2009). Transgender people of color and youth dealt with a higher incidence of suicidal ideation, hate violence, mental disorder diagnosis, Post-Traumatic Stress Disorder, and major depression than their lesbian, gay, and bisexual (LGB) or white counterparts (Mustanski et al., 2010). The research suggested a positive correlation between trans quality of life and hormone therapy, gender-related surgery, compassionate medical services, and educational and social privileges (Newfield et al., 2006).

There are many factors in the lives of transgender people that may be correlated with their generally lower than average quality of life, among them access to and receipt of gender therapy; school climate; environmental and interpersonal experiences; socio-economic status; experiences of racism, sexism, homophobia, and/or transphobia; sex education; access to healthcare and social support; and experience of emotional and physical trauma. Further research

is needed, however, to truly understand how each of these factors may be correlated with the quality of life of trans* persons as well as to examine the experiences of transgender individuals with consideration of these factors.

The research reviewed here suggests that among the factors correlated with low quality of life among transgender people, factors that are exacerbated by minority gender, racial, age and/or economic status, are: low health-related quality of life with barriers to health care and reassignment treatment; adverse academic and social outcomes related to high rates of harassment in school and low rates of teacher intervention; low mental health-related quality of life related to high rates of psychological distress and suicidal ideation; high rates of sexual risk behavior and HIV risk related to a lack of transgender-relevant sex education; high rates of unemployment, economic distress, and housing instability; and high rates of harassment and sexual violence (Wilson, 2009; Kenagy, 2005; Garofalo et al., 2006; Rachlin, 2008; Reck 2009; Mustanski, 2010).

These findings indicate that transgender individuals comprise a stigmatized, marginalized, and at times invisible group whose rights are often unjustly denied and who bravely face, and often overcome, incredible social adversity. While the researchers selected for this literature review examined the quality of life of transgender persons in various ways, this literature review aims to explore how the literature understands transgenderism and what existing findings suggest about the quality of life of trans* people, the social issues they face, and their lived experiences related to their gender.

Health-related Quality of Life

The literature suggests that transgender individuals may have lower health-related quality of life overall than the average American (Newfield, Hart, Dibble, & Kohler, 2006). One

possible explanation for this may be the barriers the population is suggested to face in accessing health care and treatment related to transitioning genders, also called reassignment treatment. Evidence to support this notion can be found in the work of Newfield et al. (2006), who found that in all aspects of health except physical and body pain, the transgender individuals that comprised their sample had significantly lower health-related quality of life than the general population. For mental health and for social functioning, female-to-male (FTM) participants reported lower quality of life than the general population. Based on their research, the authors asserted that this was because of the stress of marginalization and discrimination dealt with by the transgender population.

However, the FTMs in the sample reported significantly higher physical health than the general population (Newfield, et al., 2006). Those who had received testosterone at any time reported higher health-related quality of life scores than those who had not, with statistically significant differences in mental health. When the researchers controlled for the possible influence of income and education on quality of life, they found that testosterone usage independently predicts higher quality of life in mental health. Finally, those in the sample who had undergone top surgery reported higher general quality of life scores than those who had not received surgery. Moreover, when controlling for possible influence of income and education on quality of life, the research revealed top surgery to be an independent predictor of quality of life.

Further evidence in support of the notion that the population may face barriers to accessing healthcare is the suggestion by Rachlin, Green, & Lombardi (2008), that the population is underserved by the healthcare industry in the United States. Specifically, Rachlin et al. (2008) suggest that female-to-males (also known as FTMs or transmen) are underserved by the healthcare industry in the United States for reasons including gender-related services not

being covered by most U.S. insurance companies; lack of insurance among transmen due to economic and employment difficulties; mistreatment and harassment experienced by transmen at the hand of healthcare providers; and the historic denial of services to transmen if their gender is made known to healthcare providers. The sample of FTMs in their study was made up of generally well-connected, employed individuals with access to health-related services as a result of educational and enrichment opportunities that had been afforded them in life, according to the sample. While the sample did not represent the average FTM, the study gave insight into how the quality of life of transgender people is augmented with added educational and enrichment opportunity.

Access to healthcare may vary, however, among the transgender population itself, although the literature as a whole overwhelmingly suggests the population faces additional barriers in accessing healthcare. A study by Kenagy (2005) suggested that male-to-female (MTF) transgender individuals in the sample had greater access to health-related services and medical care than female-to-male (FTM) transgender individuals. It also suggested that significantly more white respondents than respondents of color had access to medical care. Almost a third of respondents, both MTF and FTM, had been denied medical services, but most were not sure if it was because of their gender. Half of the sample stated not being able to afford medical care. On the whole, Kenagy's work demonstrated the lack of access to healthcare experienced by female-to-male and male-to-female transgender individuals.

School-related Experiences

With regard to the transgender school experience, the literature suggests that high rates of harassment in school and low rates of teacher intervention are experienced by transgender students (McGuire, Anderson, Toomey & Russell, 2010). McGuire et al. found that harassment

of transgender youth by other students in school occurs frequently and that intervention by teachers occurs infrequently. The rate of reports of physical and verbal abuse by other students was high within the sample. Supportive adults at school were integral for transgender focus-group members who expressed feeling “safe” at school. The study also found that transgender youth in the sample made school-related decisions based not on academics but on a safe school environment for queer youth. Access to schools with greater resources were unavailable to many of the youth in the sample because of the unsafe climates for transgender youth.

The transgender youth in the sample transferred schools at a high rate, the effects of which are unknown (McGuire, et al, 2010). Transgender youth in the sample also missed a considerable amount of school due to fear of harassment/avoidance of the negative climate, the effects of which are unknown (McGuire, et al, 2010). The study also found that negative comments from peers based on the sample’s gender presentation are common and teacher or staff intervention to defend transgender students is uncommon. Students in the sample were as likely to hear negative comments by school employees as to hear school employees impede other students from making negative comments based on the sample’s gender identities. Participants expressed a belief that schools were a place of “considerable harassment” for transgender youth. Reports of physical and verbal harassment were common and reports of intervention in harassment by teachers were rare. Focus groups expressed the importance of at least one school employee who advocated for them. Focus groups also expressed alternative school environments to be more comfortable than traditional schooling.

Mental Health

With regard to the mental health-related quality of life of transgender persons, the literature suggests it to be lower than average among the transgender population, with

psychological distress and suicidal ideation among transgender individuals to be high (Mustanski, Garofalo, & Emerson, 2010). Mustanski et al. found that transgender and African-American LGBT youths were more disposed to any mental disorder diagnosis than white LGBT youths or lesbian, gay, and bisexual youths in general. However, African-American LGBT youths were found to be less suicidal than their white LGBT counterparts.

Transgender youths in the sample had the highest rate of attempted suicide over the course of their lives (Mustanski, et al., 2010). Transgender youths also had the highest Brief Symptom Inventory scores, indicating the highest incidence of symptoms of mental disorders in the sample. However, transgender youths had the lowest incidence of anorexia and bulimia. Transgender youths had very high rates of Post-Traumatic Stress Disorder (PTSD) and major depression. Racial and ethnic minority LGBT youth had higher rates of PTSD, conduct disorder, any diagnoses, and suicide attempt than their white counterparts. Another by Kenagy (2005) found high rates of attempted suicide in transgender participants related to their gender. One-third of participants in this study had attempted suicide- one third of male-to-females and more than half of female-to-males. Three-quarters of those who had attempted suicide said they did so because of their gender.

HIV and Sexual Risk Behavior

With regard to sexual risk behavior and HIV among transgender individuals, the literature suggested that transgender persons may be at high risk for HIV and have engaged in sex work at higher rates than the general population- transgender women in particular (Wilson et al., 2009; Garofalo et al., 2006; Kenagy, 2005). Wilson et al. (2009) found that in a sample of over one-hundred female transgender youth, mostly of minority racial status, over half had engaged in sex work and almost half had done so in the last three months. The odds of ever

engaging in sex work were significantly higher among those with less than a high school education, those who had ever been homeless, those who had ever been incarcerated, and those who used street drugs. Surprisingly, the study also found that transgender female youth with a history of sex work were also more likely to report having a higher perceived level of social support. The authors assert that that association may result from the fact that some of the youth in the sample felt they found a unique source of support within the transgender sex work community.

The demographics of the sample of this study also provided valuable information about the circumstances respondents were facing. Almost three-fourths of the sample had an income of less than a thousand dollars a month, almost half had been homeless, and over half had been in the correctional system, and half had experienced trouble becoming employed due to their gender (Wilson et al., 2009). Almost all of the participants had used substances including alcohol and drugs during their lives. Thus, respondents were facing significant financial and personal challenges, an awareness that provides additional context for understanding sexual risk behavior and the prevalence of sex-work among the population. Almost three-fourths of the sample had been tested for HIV and a fifth of the sample was HIV-positive. Additionally, transgender female youth with a history of sex work were more likely to have been treated in inpatient mental health or substance abuse programs. Thus, although sex work and HIV were prevalent in this sample of transgender female youth, this study also found that transgender female youth who have engaged in sex work are getting tested for HIV at high rates.

Garofalo, Deleon, Osmer, Doll, & Harper (2006) offer an alternative conclusion about this trend, postulating that male-to-female transgender youth are “at risk of acquiring HIV, but also face enormous challenges navigating adolescent and gender identity development without

readily available, culturally appropriate health care and social support services. They link higher HIV risk among the population to the lack of access to healthcare among the population previously referenced. Their study found that their sample of male-to-female (MTF) transgender youth received more social support from friends than from family; that the youth's largest life stressors are police harassment and access to transportation, employment, safe places to sleep, medical care; and suggested that the youth choose risky sexual behaviors because of misconceptions about HIV. All the youth reported having unsafe sex, most saying they considered *foregoing the use of condoms* due to HIV knowledge deficits/misconceptions they held. Also, though, the youth in the sample expressed low confidence in HIV medicines. All but one respondent reported sex with men within the past year, more than half with casual partners and without protection.

The study also rendered interesting findings related to HIV status and its relation (or lack thereof) to sexual risk behaviors and sexual victimization among the sample. For instance, respondents experienced a high incidence of sexual victimization, with more than half reporting forced sexual intercourse and intercourse in exchange for money, drugs, or shelter. A little more than a fifth of respondents were HIV positive, and of those all but one was African-American. The rate of sexual risk behaviors respondents reported was unrelated to the incidence of HIV among these respondents. This study indicated that ethnic minority MTF transgender youth experience an adolescence complicated by a broad range of psychosocial and environmental challenges inclusive of, but not limited to HIV. For youth in the sample, access to care was complicated, specifically in the case of this sample, by the dual stigma associated with being both ethnic and sexual minorities (Garofalo et al., 2006).

Kenagy (2005) confirmed the findings of other studies indicating that HIV and sexual risk behaviors were more prevalent among certain subsets of the transgender population. In particular, he found a higher HIV prevalence among male-to-female (MTF) transgender individuals. He also found that unprotected sex was prevalent among the population in the study, particularly among HIV positive respondents, and that the risk of HIV infection from unprotected sex was higher among MTFs of color than white MTFs. While less than a tenth of respondents were HIV positive, a statistically significant difference in HIV status was found among MTFs and FTMs, where ten percent of MTFs were HIV positive and none of the FTMs were. Moreover, MTFs appeared to be less informed about their HIV status than FTMs. More than two-fifths of MTFs said that they didn't know their HIV status compared with less than a tenth of FTMs. A higher percentage of MTFs of color than white MTFs were HIV positive.

That being said, the study seems to suggest that in general respondents were somewhat aware of the risk of HIV, as half had been tested in the last six months (Kenagy, 2005). About three-fifths of respondents had engaged in unprotected sexual activity during the past 12 months, though, putting themselves at risk of HIV infection or reinfection. Almost two-thirds of HIV-negative respondents and four-fifths of HIV-positive respondents who didn't know their HIV status had engaged in unprotected sexual activity during the past 12 months. Indeed, the risk of HIV infection from unprotected sex was significantly higher among people of color than among white people. More than two-thirds of respondents of color had had unprotected sex during the past 12 months compared with less than half of white respondents. Thus, the study also suggests that male-to-female transgender persons and transgender persons of color are at higher risk of HIV infection (Kenagy, 2005).

Employment, Finances, and Housing

With regard to employment, economic status and housing among transgender people, the literature suggests the population in general faces greater challenges related to employment, finances, and housing than average (Reck, 2009). This is especially true among certain subsets of the population, such as youth, transwomen, and trans persons of color. Reck's research in particular suggests that transgender youth of color experience unemployment, economic distress, and lack of housing stability at high rates. He asserts that gay and transgender homeless youth of color lack the support of a place of residence *and* a place of belonging in the broader community. He posits that they have fewer resources at their disposal, lower educational outcomes, fewer job opportunities, and fewer reliable relationships than heterosexual or white homeless youth. The findings of his study suggest that family displacement, abuse, financial instability, transphobia and homophobia contribute to transgender and gay youth homelessness. His findings also suggested that LGBT youth of color often face the dual dilemma of homophobia within their ethnic communities, and racism from white gay communities. The author posited that this may be because of the demands from each community that they value or adhere to one identity over the other.

Accounts given by respondents in Reck's study (2009) reflected that they were often treated in a contemptuous manner in public spaces - and that this was no less true within gay communities. Respondents reported having sought out a supportive community in San Francisco's gay Castro neighborhood to be able to safely express their gender and sexual identities that they could not express in their family, neighborhoods, schools or society at large but that their experiences in the Castro were not affirming, despite the respondents' identity as LGBTQ youth who are most marginalized and most in need of its services. The findings suggest

that invisibility, police and community harassment and sexualization and commodification served as manifestations of the neighborhood's unreceptive attitude toward the homeless youth of color. Reck posited that ageism, sexism, racism, and classism worked in tandem to marginalize the youths. The results of the study even point to the possibility that being excluded from San Francisco's gay community may have exacerbated and certainly perpetuated the conditions that drove them to homelessness.

Harassment and Sexual Violence

The literature suggests that the transgender population may experience harassment and sexual violence at a higher than average rate (Kenagy, 2005). For instance, Kenagy found that respondents in his study had been forced to have sex, had experienced violence in their homes, and had been physically abused at high rates, with male-to-females (MTFs) more likely to have experienced these things than female-to-males (FTMs). More than half of participants in the study reported having been forced to have sex. Additionally, more than half of participants had experienced violence in their home. Lastly, more than half of participants had been physically abused. MTFs were significantly more likely to have been forced to have sex, to have experienced violence in their homes, and to have been physically abused than FTMs.

Further Insights

In summary, the literature suggested that the mental, emotional, and physical health-related quality of life of American transgender persons is on average lower than that of the general population (Kenagy 2005; Reck 2009; Garofalo et al., 2006; Newfield et al., 2006; McGuire et al., 2010). Because these findings were reflected across multiple studies, it is presumable that these findings are somewhat generalizable to this population. The literature also suggested that hormone therapy is positive related to transgender quality of life and that

reassignment surgery is more positively related to transgender quality of life than hormone therapy (Newfield, et al., 2006). Another insight that can be garnered from this literature is that compassionate medical services and educational and social opportunity are positively related to transgender quality of life (Rachlin et al., 2008).

Additionally, the literature suggests that schools are a place of considerable harassment and abuse of students, often by other students, and without proper intervention from adults—sometimes with adult consent (McGuire et al., 2010). Findings suggest that transgender students experience adverse academic outcomes and miss more school, probably because of the harassment they receive in school. With regard to transgender youth, particularly of color, the literature suggests they may feel disconnected from the larger gay, lesbian and bisexual (GLB) community, which Garofalo et al. (2006) assert, “is often seen as predominantly white and not supportive of transgender individuals.” The literature further intimates that suicidality and HIV-risk are problems within the transgender community. Findings suggest that the low relative quality of life of transgender persons is related to unemployment, economic distress, and housing instability among the transgender community as well as sexual violence and harassment against transgender individuals.

Finally, the literature selected for analysis revealed that transgender persons deal with injustices on a broad scale, such as: low health-related quality of life with barriers to health care and reassignment treatment; adverse academic and social outcomes related to high rates of harassment in school and low rates of teacher intervention; low mental health-related quality of life related to high rates of psychological distress and suicidal ideation; high rates of sexual risk behavior and HIV risk related to a lack of transgender-relevant sex education; high rates of unemployment, economic distress, and housing instability; and high rates of harassment and

sexual violence. It also revealed that adverse experiences in the transgender community are magnified for male-to-female transgender persons, transgender youth, transgender homeless, and transgender persons of color as well as any combination of these identities. Transgender persons of color experience dual stigma within the white gay community and communities of color. It can be assumed that dual stigma is attached to transgender homeless, transgender youth, and transgender women as well. All the forms of injustice experienced by transgender persons seem to stem in part from systems of oppression and the “isms:” transphobia, homophobia, racism, sexism, classism, and ageism.

Methods

This study aimed to include as participants as many transgender Wisconsin residents as possible. Purposive non-probability sampling, specifically a snowball sampling technique, was used over four months to reach this very specific target group, as the population is difficult to pinpoint and the largest sample possible was desired. Recruitment took place through social media, word-of-mouth, and flyers distributed to nonprofits and other locations known for serving and convening the population. The sample size for the study was 29, after three incomplete surveys were thrown out.

An anonymous, investigator-developed, 21-question, online survey was used to collect demographic data about the sample and assess quality of life and discrimination experiences. The instrument was modeled on like instruments used in gender research and evaluated by a researcher in gender as well as by transgender individuals in order to increase the validity of the instrument. The quality of life section of the survey was modeled on a generic, valid, accessible, and clinically relevant tool for assessing the quality of life in a population called the Short Form 36-Item Questionnaire version 2 (SF36v2). The instrument was also field-tested before being

issued. The investigator informed participants that this research constituted a pilot study. It was also an opportunity to pilot the investigator-developed instrument.

Demographic questions focused on race, gender, biologic sex, age, sexual identity, and partner status. Quality of life indicators included annual income, housing status, health status, HIV status, employment status, level of education, financial status, mental health status, and drug and alcohol use. Questions on gender-related life experiences inquired about respondents' experiences with housing, healthcare, education, employment, and social environments. Demographic and quality of life questions mostly took the form of Likert and semantic differential scales, and free response survey questions were used to collect more in-depth data about quality of life. A free-response section of the survey was also utilized to collect data on the gender-related experiences of the sample.

Descriptive analysis was used to interpret demographic data and Likert-scaled quality of life data. Thematic content analysis was used to analyze free-response quality of life data as well as data about participants' gender-related life experiences. Free-response data was labeled and grouped according to themes that reflect the content of the data respondents shared related to each theme. These themes are used in this article to report the thematic content of the free-response data on respondents' quality of life and gender-related life experiences. The findings were credibility tested with multiple trans* Wisconsinites and a gender researcher. Findings of the study were credibility tested with *trans persons and a gender researcher.

Findings

Between August 2013 and December 2013, 32 individuals took the anonymous survey hosted on the study's website. Twenty-nine surveys rendered usable data. The survey was split

into three sections: demography, quality of life, and gender-related life experiences. The results are below.

Demography

Demographic questions focused on age, race, biologic sex, gender, sexual identity, and partner status. Table 2 summarizes the demographic characteristics of the sample.

Table 2

Participant Demography

Table 2: Participant Demography; n=29

Age		n (%)
	18-30	21 (72.41)
	30-40	7 (24.14)
	70-80	1 (3.45)
Race		
	White	17 (58.62)
	Black	4 (13.79)
	Native American	2 (6.90)
	Asian	2 (6.90)
	Multi-Racial	3 (10.34)
	Latino	1 (3.45)
Biologic Sex		
	Male	4 (13.79)
	Female	24 (82.76)
	Intersex	1 (3.5)
Gender Identity		
	Male	11 (37.93)
	Transgender	15 (51.72)
	Gender Queer	1 (3.45)
	Other	2 (6.90)
Sexual Identity		
	Lesbian	3 (10.34)
	Bisexual	1 (3.45)
	Queer	14 (48.28)
	Heterosexual	5 (17.24)
	Questioning	1 (3.45)
	Asexual	1 (3.45)
	Pansexual	4 (13.79)

Partner status		
	Married	3 (10.34)
	Partnered (including within non- monogamous relationship models)	18 (62.07)
	Single	8 (27.56)

The average participant was 18-30 years of age, white, prescribed a sex of female at birth, transgender identified, queer in terms of sexual identity, and partnered. The majority (82.78%) of the sample was prescribed a sex of female at birth, with the rest of the sample having been prescribed a sex of male (13.79%) or intersex (3.5%). Half (51.72%) of the sample self-identified their gender as transgender, with male (37.93%) following as a close second. Respondents were of varying sexual/romantic identities, with the leading sexual identities among the sample being queer (48.28%), heterosexual (17.24%), and pansexual (13.79%). Among respondents, 58.62% were white, 13.79% were African-American, 10.34% were mixed race, 6.9% were Native American, 6.9% were Asian, and 3.45% were Latino.

Quality of Life

Both scaled-format and free response questions were utilized to collect quality of life data about participants' physical health, income, employment status, level of education, housing status, mental health, drug and alcohol use, HIV status, and sexual risk behaviors. Again, the term "sexual risk behavior" is sourced from the Center for Disease Control and Prevention and was defined for participants as unprotected sex with multiple partners, engagement in sex work, or unprotected sex with a single high-risk partner. A high-risk partner was defined as one who has multiple partners, is engaged in sex work, or injects or has injected drugs. Free-response quality of life data is presented in the "free-response quality of life data" section. Quality of life

data on the sample collected through scaled-format questions is summarized in Table 3, shown below.

Table 3

*Participant Quality of Life Data***Table 3:** Participant Quality of Life Data; n=29

Physical Health:	Response Percent	Response Count
Excellent	13.79	4
Good	44.83	13
Average	41.38	12
Fair	0.00	0
Poor	0.00	0
Annual Income:		
\$0 - \$10,000 a year	27.58	8
\$11,000 - \$20,000 a year	17.24	5
\$21,000 - \$30,000 a year	20.69	6
\$31,000 - \$50,000 a year	24.14	7
\$51,000 - \$70,000 a year	0.00	0
\$71,000 - \$100,000 a year	10.34	3
Employment Status:		
Unemployed	17.24	5
Employed part-time	20.68	6
Employed full time	55.17	16
Student	6.90	2
Level of Education:		
No diploma or degree	6.90	2
A high school diploma	27.59	8
Current college student	3.45	1
An associates or trade degree	10.34	3
An undergraduate or bachelor's degree	27.59	8
A master's or equivalent graduate degree	24.14	7
A terminal degree	0.00	0
Housing Status:		

Have a fixed residence (rent or own)	65.52	19
Temporary/intermediary housing with a friend or family member	31.03	9
Live in a shelter/homeless	3.45	1

Mental Health:

Excellent	24.14	7
Good	41.38	12
Average	13.79	4
Fair	10.34	3
Poor	10.34	3

Drug Use:

Very Frequent	6.90	2
Frequent	6.90	2
Occasional/Social	13.79	4
Infrequent	13.79	4
Never	58.62	17

Alcohol Use:

Very Frequent	10.34	3
Frequent	13.79	4
Occasional/Social	58.62	17
Infrequent	13.79	4
Never	3.45	1

HIV Status:

Positive	6.90	2
Negative	86.21	25
Unsure/haven't been tested	6.90	2

Engagement in Sexual Risk Behaviors:

Very Frequent	3.45	1
Frequent	3.45	1
Occasional	6.90	2
Infrequent	13.79	4
Never	72.41	21

The vast majority of participants ($\approx 86\%$) considered themselves to be in good or average physical health. The leading income bracket among participants was \$10,000 a year or less ($\approx 28\%$), followed closely by the \$30,000-\$50,000 ($\approx 24\%$) and then the \$20,000-\$30,000 bracket ($\approx 20\%$). The \$10,000-\$20,000 and \$100,000 or more brackets brought up the rear and $\approx 17\%$ and $\approx 10\%$ respectively. The average income of respondents was $\approx \$27,000$, slightly lower than the average personal income in the United States of \$28,000 (U.S. Department of Commerce, 2014). Thus, the majority of respondents were poor or lower middle class, by income classification. More than half of respondents were employed full time, with part time employment being the second most common employment status and unemployment being the third. The unemployment rate among the sample was more than twice the U.S. unemployment rate of 6.6% listed for 2014 (U.S. Bureau of Labor Statistics, 2014). In terms of level of education, respondents were evenly split between possessing a high school diploma and an undergraduate/bachelor's degree (both $\approx 27\%$). Slightly fewer respondents ($\approx 24\%$) had master's or equivalent graduate degrees. Comparatively, the average level of education of Americans is a high school diploma (U.S. Department of Commerce, 2013).

In terms of housing, a good majority of respondents ($\approx 65\%$) had fixed residences; either renting or owning. Still, a considerable 31% of respondents only had temporary housing with a friend or family member. This reinforces the suggestion of the literature that housing instability may be prevalent for this population. While only 3% of respondents were homeless (a low proportion relative to the findings of the literature), this was a far higher proportion of homelessness than among the U.S. population at large (.2% in 2013) (National Alliance to End Homelessness, 2013). The vast majority of participants reported being in excellent, good, or average mental health. Only $\approx 20\%$ of respondents reported being in fair or poor mental health,

even though more than half of respondents reported having dealt with depression. Moreover, a broad majority of respondents ($\approx 73\%$) reported engaging in drug use never or infrequently. For the most part, alcohol use among respondents was social and considered normal relative to the broader population and certainly relative to other Wisconsinites. Still, a considerable proportion ($\approx 23\%$) of respondents did report using alcohol frequently or very frequently.

The HIV status of respondents was overwhelmingly negative (86.21%). Approximately 7% of participants reported being HIV positive and the rest were unsure of their HIV status. This is markedly lower than the incidence of HIV among the trans* population suggested by the literature. The rate of engagement in sexual risk behaviors among the sample was considerably low; $\approx 86\%$ of respondents reported engaging in sexual risk behavior never or infrequently. It is worth noting, however, that $\approx 14\%$ of respondents reported engaging in sexual risk behaviors occasionally to very frequently.

Free-response Quality of Life Data

Free-response questions were also used to collect qualitative data related to these same quality of life measures. Several notable themes emerged from the free-response data collected on the quality of life of respondents.

Financial challenges. Many respondents expressed facing financial challenges related to significant medical and student loan debt. The majority of respondents ($\approx 75\%$) shared financial concerns in the free-response section related to income, which asked respondents to detail more information about their financial health. Respondents reported having significant student loan and medical bill debt.

I have a lot of debt. I am unsure of how much debt I have exactly but would estimate more than \$50,000. All of my debt is medical related, most of which is related to transition needs. I have never filed bankruptcy.

Some respondents were able to achieve relative financial stability despite crippling debt, but expressed ongoing financial difficulty nonetheless.

I have almost \$120,000 in student loan debt, and--between my partner & I—have about \$12,000 in credit card debt. Thankfully, we own our home & bought both our cars outright. We live paycheck-to-paycheck and can save very little (total savings is currently <\$100), and I do float bills past due dates and occasionally we have to borrow money from our families to get through. It sucks. My partner—who is also trans--did not complete college yet (he's 30) and is having a really hard time finding a job to supplement my income.

One respondent expressed that even with health insurance through their employer, medical and school debt were still a great financial burden.

I have college loans that I am still paying for and am not as settled financially as I would have hoped to be at this stage of my life. Also, I have great bills related to my transition, even with my insurance through my employer.

There were one or two outliers among the sample who expressed feeling financially comfortable or well-off.

I come from an upper middle class background. My family paid for my schooling (in-state) and I haven't had any debt from school. My parents also paid for most of

the costs associated with top surgery and were my caretakers, so even though I have had a limited income since graduating school, I still consider myself to be well off in terms of class and financial access.

These findings reflect what is suggested by the literature about the financial well-being of the trans* population, which is that the population faces significant financial instability (Reck, 2009).

Health challenges. While $\approx 45\%$ of respondents expressed being in good health, 41% reported being in average physical health. Of respondents who reported being in average physical health, $\approx 50\%$ reported dealing with physical illness or challenges unrelated to their gender. These challenges included allergies, asthma, high cholesterol, hyperthyroidism, osteoarthritis, irritable bowel syndrome, and multiple chemical sensitivity. Respondents expressed the difficulty of dealing with these gender-unrelated ailments and in some cases articulated that they felt those ailments were exacerbated by stress related to their gender and/or transition. One respondent expressed the difficulty of functioning with multiple chemical sensitivity:

I have Multiple Chemical Sensitivity (also known as Environmental Illness), which can cause severe physical (nausea, passing out, body pain, dizziness, headaches, trembling, etc.) & cognitive (difficulty communicating & with word production/comprehension, inability to focus/concentrate, much slower thinking/processing, etc.) reactions when I am exposed to chemicals or scents.

Another respondent expressed that stress related to their gender can exacerbate their ailment:

I have Irritable Bowel Syndrome, which is unrelated to being trans, however stress can trigger flare-ups... and being trans can bring about stress from time to time.

This information is pertinent to the quality of life of the population because the literature suggests that transgender persons face more environmental stressors and higher levels of psychological distress than the average person and stress could exacerbate certain of the physical ailments respondents suffer from (Mustanski et al., 2010).

Mental health challenges. Many of the respondents expressed having grappled with difficult mental health issues. A majority of respondents ($\approx 51\%$) had experienced or were experiencing depression. Furthermore, $\approx 28\%$ of respondents reported that they had attempted suicide over the course of their lives, a far higher proportion than is suggested among the trans* population by the literature (6.5%) (Mustanski et al., 2010). Additionally $\approx 20\%$ of respondents reported experiencing gender dysphoria, or discontent with one's self and one's body due to a feeling of incongruence between one's body and one's gender identity. A significant proportion of respondents ($\approx 24\%$) however, reported their mental health having improved once they acknowledged trans* identity or transitioned. This respondent expressed feeling depressed less often since starting hormone therapy:

There are days where I have an overall general feeling of sadness and depression.

However, those days are much fewer and farther apart since beginning hormone

therapy. Part of that I believe comes from no longer feeling as though nothing could be done to align my outward appearance to who I am inside.

This respondent recounts having dealt with eating disorders and having attempted suicide before coming to terms with their trans* identity and experiencing dysphoria prior to having a double mastectomy. The respondent reports feeling much less depressed since the surgery and with the support of a caring partner:

I experienced depression last year related to transition (more so to lack of progress in transition and having an unsupportive partner at the time). After undergoing top surgery and leaving that relationship, I have been significantly less depressed with regards to my transition status and have found an extremely supportive and caring partner. Dealt with eating disorders and suicide attempts earlier in life while I was in denial about my trans* identity.

This respondent reports significant improvement in their mental health since starting hormone therapy:

I've certainly had my run-ins with anxiety and depression, but since starting testosterone I've been great. Initially I had ups and downs as my hormone levels balanced out, but certainly nothing like it used to be.

Multiple respondents reported their entire lives having improved markedly after coming to terms with their trans* identity or transitioning:

I am very happy with my life right now, especially after coming to terms with my trans* identity. I have not dealt with depression for many years - since I was about 12 years old and first began identifying as lesbian.

“My whole world has gotten exponentially better since my transition.”

The respondents' reports of high incidence of depression and suicidality reflect the literature's suggestion that psychological distress and suicidal ideation among transgender individuals is high (Mustanski et al., 2010). The experiences the respondents report related to hormone therapy and transitional procedures helping to improve their mental health mirrors the literature, which states that trans* individuals who received hormone therapy reported higher health-related quality of life scores than those who had not, with statistically significant differences in mental health (Newfield, et al., 2006). Even when the researchers controlled for the possible influence of income and education on quality of life, they found that hormone therapy usage independently predicts higher quality of life in mental health (Newfield, et al., 2006).

Challenges accessing mental health resources. Also within the mental health free-response section, a small but significant proportion ($\approx 20\%$) of respondents experiencing mental health issues reported not being able to access resources or services related to their mental health because of lacking health insurance or being unable to afford services. This respondent expressed having recently received a mental health diagnosis for which they cannot afford to procure medicine:

I was just diagnosed with Bi-Polar disorder and Borderline Personality Disorder. I believe I have mild schizophrenia. I have been off my meds for 3+ months. No insurance.

Another respondent expressed not being able to procure counseling for the mental health issues they face related to past trauma due to the considerable financial expense of those services:

I have some struggles with anxiety and short-term depression, as I am a survivor of abuse from my father, abuse from a partner & sexual assault. I have a number of triggers & do my best to manage them. I have not been able to seek counseling for some time, as my previous job did not have mental health coverage in the insurance, and I currently cannot afford the co-pays, as my partner is unemployed.

The literature also suggests what these findings seem to show, which is that trans* people are underserved by the healthcare industry, including access to mental health services (Rachlin et al., 2008).

Housing. The vast majority of respondents ($\approx 66\%$) are in fixed or permanent housing situations, either renting or owning. Another $\approx 31\%$ of respondents are in temporary housing situations, living with friends or family members, and a remaining $\approx 3\%$ are homeless or living in a shelter. One homeless respondent reported feeling like the stress related to being trans* influenced the drug addiction, which they perceived as the cause for having been homeless:

I feel like my drug addiction was greatly impacted by my gender identity crisis which caused me to be homeless. I understand and take full responsibility for my drug addiction, but cannot deny that it was a big factor.

Of note is the fact that $\approx 33\%$ of those in temporary housing reported that they are hiding their transgender identity from those they live with, out of fear of being kicked out. One respondent expressed this concern about his father:

I still live with my parents but only one of them knows of my transition because I worry about my father's reaction when he finds out.

The low overall incidence of homelessness challenges the suggestion of the literature that homelessness is prevalent among the trans* population (Wilson et al., 2009), but of note is the fact that the incidence of homelessness among the sample was higher than the incidence of homelessness among the general U.S. population (3% among the sample versus .2% among the U.S. population) (National Alliance to End Homelessness, 2013). The literature suggests that trans* youth (under age 18) of color are at a much higher risk of homelessness than white, adult trans* individuals (Reck, 2009).

Gender-related Life Experiences

Free response write-in questions were utilized to collect data about the gender-related life experiences of the respondents. The free-response questions inquired about the support respondents received from their families related to their transgender identity and/or transition, the support respondents received from their personal network (other than their family and partner(s)) related to their transgender identity and/or transition, respondents' gender-related

healthcare experiences, respondents' gender-related employment experiences, and also about any other gender-related life experiences respondents wanted to share. Several important themes emerged from the qualitative data collected.

Familial Support. In general among respondents, family support was reported as being high, although a significant portion of respondents expressed having been estranged from their families or members of their families in the past. A vast majority of the sampler ($\approx 63\%$) reported having families and partners that were supportive of their transition and/or transgender identity. Approximately 21% of the sample reported having been kicked out or disowned by their family when they came out. Approximately 16% of respondents were not out to their families. Of the respondents who reported feelings supported by their families and partners, $\approx 47\%$ reported having been disowned/estranged from or having had broken relationships with their families that became repaired over time. Overall, respondents reported that their partners were a greater source of support than their families. Comments regarding family support include details about familial relationships and respondents' experiences of being estranged from or disowned by their families upon coming out:

My parents were a hard sell. They stopped talking to me for a short period of time, and they still have issues; however, they are working at everything and are 1000X better today than a year ago. They rarely ask about my emotional state or show concern for me. The rest of my family were and are amazing. My wife has known I was trans for 18 years and we've been married for 8 of those... she is my rock.

My mother and step-father did disown me for a brief period of time. It took some family meetings with my aunts to begin the healing process. However, the relationship is still broken in places and my transition is not discussed.

I was never officially kicked-out of my family or disowned, but my mom did not speak with me except when absolutely necessary & treated me like shit for 3+ years.

At first my parents didn't understand and stopped talking to me but now two years later we have been talking like we never stopped.

Personal Network Support. In general, respondents reported that support from their personal networks was high and respondents expressed considering that support to be vital. A vast majority ($\approx 69\%$) of respondents expressed feeling supported by the personal network they keep outside of their family and partner(s). Approximately 15% did not feel supported and the same proportion felt their personal network was neutral in terms of support. Comments made by respondents who felt supported by their personal network illuminate just how important that system of support was:

If anything, more often than not, people are almost too concerned with my wellbeing... It's a good problem to have. Coworkers, friends have all been excellent. I've never lost a friend because of my transition, and I've gained so [emphasis added] many more since my transition.

“I had an excellent supportive community and friends.”

“I used to lead a transgender support group and have a small circle of FTM friends who were indispensable during early transition.”

I did & do have amazing friends, who even pooled money so that I could get my name legally changed in 2006. I continue to have these and other wonderful people in my life who I consider closer than my biological family.

One respondent expressed having felt most judged and unsupported by the lesbian, gay, and bisexual community than by the rest of their personal network:

I've encountered more opposition or mis-education from the LGB community than any other demographic.

Gender-related experiences in the workplace. Respondents in general reported mostly positive experiences at work; a minority reported having had significant negative experiences. Specifically, approximately fifty-eight percent of respondents reported that their experiences at work related to their gender identity/transition were mostly positive. Approximately 29% of the sample reported that their experiences at work related to their gender were mostly negative; the majority of these reported having been harassed or treated rudely at work during or related to their transition. The remaining $\approx 13\%$ of the sample reported not being out at work. One respondent who reported positive experiences at work related to their gender also expressed feeling lucky because of this fact:

I am incredibly privileged to have had such positive support at work. From the moment I came out, my colleagues have embraced me as male and have had no issues with the name/pronoun change. I am very lucky!

Respondents who reported that their experiences at work related to their gender or transition were mostly negative described feeling tokenized, having been verbally harassed, and having coworkers who refused to honor their preferred gender pronouns. Many also reported that their experiences improved over time or that management intervened to address the issue. Some of the respondent comments were as follows:

In the beginning of my transition process, I was treated sparingly at work. People really didn't have much to say to me, or I to them. After approximately a year, most of my co-workers were able to honor my preferred gender pronouns and treated me with respect.

I have been verbally harassed on the job in relation to being transgender. However, my senior manager and HR team worked quickly to resolve the issue.

I had 2 weeks of out of store management training before being promoted at my last job (pre-hormone therapy). The general manager at the training store refused to use preferred pronouns and specifically told everybody else not to as well.

I have been tokenized as the 'trans* employee' for my entire working life after transitioning and been put in the position of being made to speak for all trans*

people, do all the trans* work, etc. I have been denied work & been told my 2 or 3 employers to my face that this was why they weren't hiring me.

Gender-related experiences in healthcare. Respondents reported having had diverse healthcare experiences, but were generally dissatisfied with healthcare providers' level of knowledge about transgenderism. A slightly larger proportion of respondents ($\approx 44\%$) reported that their healthcare experiences related to their gender and/or transition were mostly positive than reported that their healthcare experiences related to their gender and/or transition were mostly negative ($\approx 36\%$). The other approximate 20% of the sample reported either having mostly neutral or no healthcare experiences related to their gender and/or transition.

Respondents who reported that their healthcare experiences related to their gender and/or transition were mostly positive indicated having had positive experiences with healthcare obtained through recommendations by other trans* people and through Veterans Affairs:

I chose my medical providers based on recommendations from those in the trans* community. I have been shown nothing but absolute positive care from all of my providers. They include: primary care physician, endocrinologist, psychologist, and mental health therapist.

“I've been using the Veterans Affairs healthcare system. They are very supportive.”

Among respondents who reported that their healthcare experiences related to their gender and/or transition were mostly neutral, respondents mentioned having to educate healthcare

providers about transgenderism and feeling that knowledge of transgenderism is lacking among healthcare providers:

“Experiences would be better if I didn't feel like I was educating my providers on all aspects of my identity and transition status.”

“Healthcare providers are clueless, but no big negative experiences.”

“I haven't been treated poorly, but I feel like knowledge of transgender care is lacking.”

Among respondents who reported that their healthcare experiences related to their gender and/or transition were mostly negative, the following comments were shared:

“[I was] shamed for binding safely with a binder by a doctor during an unrelated doctors visit (not for breathing problems or rib/chest problems).”

I have experienced medical professional staff in OB/GYN offices being rude and purposefully disrespectful by announcing me by my birth name or making comments in regards to my genitals.

One time in the ER a male nurse became so obsessed with my gender appearance versus the sex on the chart that I had a panic attack because I believed he may not do everything he could to save me.

I was not given adequate training in giving myself injections for Hormone Replacement Therapy (a nurse kind of showed me and I ended up asking another nurse I knew to come to my house and go through the steps...then I provided training for my friends, who were not trained at all), was often confused about which name to use during intake and during appointments before my legal name was changed, was made to feel like I was confusing or not make sense by a nurse practitioner. The intake process can be uncomfortable when an option for my gender has not been present and then I need to clarify during an appointment.

These findings mirror what is suggested by the literature about trans* healthcare experiences, which is that trans* persons are considerably underserved by the healthcare industry and may even face harassment at the hands of healthcare providers (Rachlin et al., 2008).

Harassment and safety. Respondents generally reported a prevalence of verbal and physical harassment as well as feelings of perpetual physical and/or emotional unsafety related to their genders. Additionally, some respondents of color reported experiencing dual stigma based on their race and their gender identities. When asked to describe any other significant life experiences related to their gender or transition, respondents shared considerable instances of verbal and physical harassment and bullying. Approximately 63% of respondents reported having been harassed or bullied related to their gender or transition. Another 37% of the sample reported never having been harassed or bullied related to their gender or transition. Respondents detailed past experiences of harassment, trauma, and bullying by strangers, family members, teachers, and partners:

“[I’ve] had people shout at me from their cars. A homeless woman called my partner and I disgusting and threaten to kill us/beat us with a stick.”

I was called a stupid fucking tranny bitch once... I have been mis-gendered and asked to ignore the fact that it impacted me, by people in authority. I've also been asked to explain in front of groups of people what my gender means. I've been asked publicly about my genitals and how I have sex (this is something that happened before as a queer woman as well).

I was bullied all throughout grade school for presenting as male and was once pulled out class by a teacher and told, "If you don't like being bullied so much, why don't you just dress like a girl?" There were numerous other times when I had been bullied and harassed, but I feel like that was one of the most significant. On other occasions, I have been called dyke, tranny, among other things directly related to my gender identity.

“[I] have experienced verbal harassment due to my gender identity – particularly in men's rooms where I've been called a fag and have been chased out of the restroom.”

My father tried to harass, bully, abuse & beat me into being a girl, especially a thin & gender conforming one. I was taunted & physically bullied for my body, weight & gender throughout school. My first partner tried to abuse & rape me into

being a gender conforming woman. I was recently approached on the street and told by this smiling stranger that he was going to beat me up & rape me because of my gender & sexuality. It is constant. It is everyday. I do not feel safe in most public places, because people read me as a gay man or know me as a trans* person; and I do not feel safe in gender segregated spaces, because I know that I will get hurt/beat/harassed/etc. if someone sees my body.

Since beginning my transition I've encountered racial profiling by law enforcement since I appear and present as a black male. My gender and name have yet to be changed on my ID. I've experienced officers making comments about me being a freak or how they feel like I tried to trick them because I did not disclose this information to them even though its not relevant to a "routine" traffic stop. I've experience being threatened of a cavity search. I've also experienced being flagged at the airport almost every time I fly. When being checked I've had searches that included men and women being present in the room or area because were unsure of how to proceed. I've experienced being let go before being searched because no one wanted to touch me.

I was recently kicked out of a recreational sports league that was made up of men (at and beneath my skill level) because of my gender identity. It was a bowling league in Waterford, WI and it was solely due to my transition. Their justification was: "This is only a men's league, and people don't know what I am." I was told

that I make people feel uncomfortable. I was kicked off of my tournament team, because at least one bowler out of the five is uncomfortable with me.

I have not been allowed at certain family events and have been told that I don't make sense, been called a freak. When I was traveling, my bra showed up on the x-ray thing at the airport and I was read as male so a male agent came and touched my breast, asking what was under my shirt...without consideration of whether or not I had breasts at the time... [The] discrimination, harassment, and bullying that happens to people like me and that impacts my ability to feel safe.

The majority of mistreatment has been from individuals within the queer community who believe that they are trans* allies and while they may be well-intentioned, make matters worse by outing me (e.g. If someone misgenders me, someone may respond to that with "It's alright, he's a trans guy," rather than simply correcting the misgendering.

I have been refused service because my ID didn't match me & because I looked like a "freak." I have been laughed at. I have been chased out of changing rooms & bathrooms & locker rooms. I have had cars slow down just so that the folks in them can try to spit on me & call me a faggot & threaten to beat or rape or kill me.

These findings mirror what is suggested by the literature about the incidence of harassment and verbal and physical abuse among the trans* population, which is that it is high (Reck, 2009).

Discussion

The findings of this study indicate that trans* Wisconsinites comprise a demographically diverse population in terms of age, race, and sexual identity. It also suggests trans* Wisconsinites to be diverse in terms of quality of life, especially with regard to income, level of education, housing status, and mental health. The findings reflect the suggestions of existing literature that transgender persons often face harassment, mental health and financial challenges, housing instability, lack of access to care and services, and identity-related stresses, additional to what the average American faces. Specifically, the study suggests that trans* Wisconsinites face considerable financial challenges based on significant medical and student loan debt, which mirrors the suggestion of the literature that the population faces considerable financial instability (Reck, 2009).

Furthermore, the findings of this study suggest that trans* Wisconsinites face health challenges unrelated to being transgender, which are in some cases exacerbated by the environmental and psychological stress respondents experience related to being transgender or transitioning. The findings also suggest a prevalence of depression and attempted suicide among trans* Wisconsinites, but confirm the assertion of the literature that mental health status improves when trans* persons progress in their transition or acknowledge their transgender identity. Moreover, the findings suggest some lack of access to mental health resources among the population. Finally, the findings suggest a low incidence of homelessness among trans* Wisconsinites relative to the literature (Wilson et al., 2009), but a higher incidence than among the U.S. population (National Alliance to End Homelessness, 2013). Further, the findings

suggest that a significant proportion of the population are not in stable living situations or are hiding their transgender identity from those they live with.

With regard to gender-related life experiences, the findings suggest that despite relationships with family having been broken or lost, trans* Wisconsinites feel supported by their families. The findings also suggest that support from trans* Wisconsinites' personal networks is high and considered by them to be crucially important. Furthermore, the findings suggest that trans* Wisconsinites have diverse healthcare experiences related to their gender, but are overwhelmingly dissatisfied with the level of knowledge of transgenderism of their healthcare providers. The findings further suggest that trans* Wisconsinites experience a high incidence of verbal and physical harassment and feel perpetually physical and/or emotionally unsafe, which mirrors the literature's suggestion that harassment and abuse is prevalent among the trans* population (Reck, 2009). Additionally, findings show that trans* Wisconsinites of color experience the dual stigma and oppression of embodying two (or more) oppressed/disadvantaged identities.

While in many ways the findings of this study uphold what is suggested by the existing literature- especially with regard to employment being low, harassment being prevalent, mental health issues being prevalent, the positive correlation between transitional care and mental health, and the dual stigma/oppression faced by trans* persons of color, the study also challenges what is suggested in existing literature about familial and community support being low, physical health being low relative to the general population, and sexual risk behavior being high. However, the population does report facing significant mental health challenges, facing significant financial concerns and having substantial debt, experiencing considerable harassment and abuse, and experiencing healthcare providers as under-informed about transgender care.

By and large, the findings of this study reflect the complex and diverse demography, quality of life, and gender-related life experiences of the Wisconsin trans* population and suggest the population to face considerable social challenges and display marked resilience. The findings do suggest the population faces lack of access to compassionate healthcare, adverse gender-related life experiences within educational, corporate, and other institutions, and face uncertainty related to the stability of their housing and the social reception of their coworkers, family, and peers. The lesbian, gay, and bisexual community is not exempt from this, as the findings suggest this community can be even less accepting than the broader community. The findings also suggest that the population feels emotionally and physically unsafe a considerable amount of the time.

It is important to note that this sample was made up of predominantly young, white, trans* persons whose biologic sex was prescribed as female whilst the literature suggests that trans* persons of color, trans* youth, trans* elders, and trans* persons embodying any intersection of socially disadvantaged identities likely face considerably more challenges, especially related to housing, treatment by family and community, mental health, and harassment and abuse. It is also important to consider that the most disadvantaged and disenfranchised trans* persons may not be connected to a community of support and thus may not be represented in the sample, as a systematic snowball sampling method rooted in outreach to trans* support and service associations/organizations was used.

Additionally, the findings of the study reinforce that few social/systemic supports exist for transgender people. Institutions in which the participants experienced discrimination did not, according to participant reports, have systems in place to educate employees on gender diversity or to support transgender individuals. This study ultimately reflects the suggestion of existing

literature that transgender persons often face significant social challenges and harassment, face mental health and financial challenges, deal with housing instability, often lack access to care and services, and face additional identity-related stresses, both physical and emotional, to what the average American faces.

The findings of this study also seem to uphold what is suggested by the existing literature that there is a positive correlation between transitional care and mental health, and that trans* persons of color face dual stigma/oppression because of embodying multiple disadvantaged/oppressed identities. That being said, the study findings also challenge what is suggested in existing literature about participant perceptions of low familial and community support, physical health being low relative to the general population, and sexual risk behavior being high. Finally, given the significant accomplishments and resilience of the population, this study suggests that although often underserved, misunderstood, and mistreated, the population is markedly buoyant and irrepressible.

Conclusion

Research Limitations

The limitations of the study become clear in evaluating its qualitative validity. The primary investigator evaluated this study in terms of transferability, dependability, confirmability, credibility, and authenticity, where transferability serves as a qualitative alternative to external validity; dependability to reliability; confirmability to objectivity; credibility to internal validity; and where authenticity seeks to measure the credibility of the findings with respect to the wider political and social implications of the research (Trochim, 2006; James, 2008). Limitations of the study include the low transferability of the findings due to the geographic specificity of the sample population. The primary investigator anticipated this

weakness before conducting the study and was comfortable with it because the goal of the study was to describe and illuminate the trans* population of Wisconsin in specific. The findings may be transferable to the trans* populations of other Midwestern states, however.

Another possible limitation of the study is the difficulty of determining the dependability of the study due to the dearth of demographic data on the trans* population, especially the trans* population of Wisconsin. Moreover, the dependability of the study may be limited due to the sample being comprised mostly of white respondents between the ages of 18-30, which literature would suggest is not wholly representative of the demography of the broader trans* population. If it can be assumed at all that the demography of the trans* population in Wisconsin mirrors the demography of the general population of the state, which is likely a safe assumption at least with regard to race, then the demographic data on the sample may be fairly dependable.

Another limitation is that there may have been flaws in the design of the instrument that skewed the findings. Worth noting, however, is that steps were taken to strengthen the validity of the instrument. The instrument was modeled on like instruments used for demographic and quality of life gender study and the face validity was tested with other researchers in the realm of gender study as well as with two trans* identified individuals. These individuals expressed that the findings mirror their reality and their perception of the general lived experiences of trans* Wisconsinites. Also, the instrument was revised based on feedback from trans* persons. The sample for this study was seen by the primary investigator as being of a viable size for a pilot study as well as to pilot the instrument.

Other limitations may include the fact that the confirmability of the study is difficult to assess and may be limited, considering the original survey instrument, the difficulty of recruiting participants from the target sample population, and the dearth of existing data on the population

against which to compare the findings. Also, the survey asked respondents to disclose some extremely personal information from participants. Despite the survey being anonymous, the nature of the questions may have dissuaded participants from answering or made them feel unable to answer honestly.

Finally, the sample was not large enough to analyze associations between demographics and quality of life indicators, as the investigator would have liked to. This limited the capacity of the investigator to uncover or describe relationships between demographic and quality of life data. While the overall trustworthiness of the findings is difficult to determine, the study is strong in terms of credibility and authenticity. With regard to credibility, the trans* individuals and gender researchers who reviewed the findings expressed confidence in the truth of the data. With regard to authenticity, the study is strong in that the findings clearly articulate the vast diversity of the lived experiences and quality of life of the sample and the investigator does not make generalizations or exaggerated claims about the population.

Future Studies

The experiences and reality of the transgender population, as an overarching research topic, is so complex, multidimensional, and understudied, that there is much to be desired in terms of literature. A great deal of further research is needed to truly understand the trans* population in the United States and their lived realities. Specifically, further study of the experience of transgender persons living in distinct locales, such as the Midwest, is needed. Additionally, further research is needed on the experiences of transgender individuals in specific systems and institutions such as the healthcare system, the education system, the workforce, etc. Studies of these specific institutions and their policies related to gender diversity would add valuably to the body of knowledge on the topic, as would further studies of the current healthcare

experiences of transgender Americans, since research suggests they avoid and are denied healthcare at high rates (Rachlin et al., 2008).

Furthermore, an interesting and valuable topic of research related to transgenderism would be to explore how public and media portrayals of transgender individuals are associated with their quality of life and with the public perception of transgenderedism. More practically, research is needed to test the efficacy of programs being put in place to address unequal treatment of transgender persons, such as diversity education initiatives and employee trainings. Sociologically, studies on the multiplicity and intersectionality of the identities of transgender people and the dual oppression experienced by transgender people who embody multiple oppressed identities, such as transgender people of color, youth, women, etc. would also be illuminating. Finally, there is a dearth of research to explain why transgender women engage in sex work. Research in any and all of these topics would help to progress our understanding of the transgender experience, how to deconstruct cultural and systemic transphobia, and how to achieve social equality and improved quality of life for trans* people.

Concluding Remarks

This study is a first step in better understanding the trans* population of Wisconsin. It is the hope of the author that this study be used to promote action that will improve the quality of life and assist in the achievement of social equality for transgender people in Wisconsin and throughout the United States. Intensive measures are needed to address the social issues this study and the literature suggest transgender persons often face, including harassment, mental health and financial challenges, housing instability, lack of access to care and services, and identity-related stresses, both physical and emotional, beyond what the average American faces. Impactful action to this end may include undertaking further research, educating the public and

raising awareness about the social issues faced by transgender population; providing direct service or establishing service organizations to address the immediate needs of the transgender population; and advocating policy that will help to socially equalize and affirm transgender persons. Specifically speaking, social interventions and multi-sector resource alignment are required to increase trans* access to existing resources and services, especially to healthcare and health-related resources.

Broad-based cultural sensitivity and diversity education efforts are needed to increase the prevalence and accessibility of compassionate, trans*-aware healthcare services. This includes mental health resources. Supportive, collective, peer spaces created by and for trans* people could serve to support the mental well-being of the population. Furthermore, targeted efforts around ensuring fair and supportive housing available to trans* persons would improve the quality of life of the population. Efforts to encourage the gay, lesbian, and bisexual (GLB) community as well as society at large to become more accepting and inclusive of transgender persons would help to eliminate transphobia and augment transgender quality of life. The lesbian, gay, and bisexual community, especially the white community, must come to “acknowledge that divides between them and youth are both generational and linked to privilege” and extend compassion and camaraderie to transgender youth of color (Reck, 2009).

It is clear that broad-based outreach, education, services, and policy change would be useful in augmenting the quality of life and lived experiences of trans* people. This work, in addition to the specific recommendations above, would take the form of awareness campaigns, cultural competency trainings, direct services, institutional policy implementation, political lobbying, and other targeted techniques. Housing, healthcare, financial, and employment-related direct services could help curtail some of the social issues faced by transgender persons. Policies

to ease the process of changing sex markers on official documents; eliminate sex markers from common forms of identification such as driver's licenses; establish third-gender restrooms in institutions such as schools; protect transgender persons seeking healthcare, housing, and employment; and institute nation-wide marriage equality could also drastically improve the lives of *trans persons. It is the author's hope that the findings of this study be applied for the purpose of further research, awareness, education, and policy to eliminate transphobia, establish social equality for, and improve the quality of life of transgender persons in Wisconsin, in the Midwest, and throughout the United States.

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Appendix A: IRB Approval Letter



Office of Research Compliance

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August 13, 2013

Claire Van Fossen
Professional Studies

Dear Ms. Van Fossen:

Your protocol number HR-2607, titled, *"Quality of Life and Discrimination of Transgender Individuals in Milwaukee"* was expedited on August 13, 2013, by a member of the Marquette University Institutional Review Board.

The IRB granted a waiver of documentation of consent for this protocol because the research presents no more than minimal risk to participants and the survey would not require a signature outside the research setting. Your online consent document is approved as written.

Your stamped recruitment flyer is attached with this letter. Please use stamped copies for recruitment purposes.

Subjects who go through the consent process (complete the consent portion of the survey) are considered enrolled participants and are counted toward the total number of subjects, even if they have no further participation in the study. Please keep this in mind when conducting your research. This study is currently approved for 100 subjects.

If you need to increase the number of subjects, add research personnel, or make any other changes to your protocol you must submit an IRB Protocol Amendment Form, which can be found on the Office of Research Compliance web site: <http://www.marquette.edu/researchcompliance/research/irbforms.shtml>. All changes must be reviewed and approved by the IRB before being initiated, except when necessary to eliminate apparent immediate hazards to the human subjects. Any public advertising of this project requires prior IRB approval. If there are any adverse events, please notify the Marquette University IRB immediately.

Your approval is valid until August 12, 2014. Prior to this date, you will be contacted regarding continuing IRB review.

An IRB Final Report Form must be submitted once this research project is complete. The form should be submitted in a timely fashion, and must be received no later than the protocol expiration date.

If you have any questions or concerns, please do not hesitate to contact me. Thank you for your time and cooperation.

Sincerely,

Amanda J. Ahndt, RN, MS, MSN, CIM, CIP
IRB Managercc: Dr. Christopher Okunseri, IRB Chair
Dr. Jay Caulfield, Professional Studies
Ms. Sherri Lex, Graduate School
Ms. Emily Hernandez, Professional Studies

Enclosure

Appendix C: IRB Approved Survey Instrument

Participant Survey Demographics, Quality of Life, and Discrimination Experiences of Transgender Individuals

*Please read each question carefully and **circle ALL answers that apply**, filling in blanks where necessary. The purpose of this study is to increase understanding and awareness of the experiences of transgender individuals in order to improve/increase services for this population.*

Section 1: Demographics

1. In terms of gender, I identify as:

a. Male

b. Female

c. Trans

d. Two-spirit

e. Gender queer

f. Other: _____

Use this space to elaborate on why you identify as you do and what the language of your identity means to you:

2. By heritage, I am:

- a. White American
- b. Black or African American
- c. Native American or Alaska Native (Tribe: _____)
- d. Indian
- e. Chinese
- f. Filipino
- g. Hmong
- h. Pakistani
- i. Cambodian
- j. Japanese
- k. Korean
- l. Vietnamese
- m. Native Hawaiian
- n. Guamanian or Chamorro o.
- o. Samoan
- p. African (Country: _____)
- q. Other Asian (Country: _____)
- r. Other Pacific Islander (Country: _____)
- s. Cuban
- t. Mexican American/Chicano
- u. Puerto Rican
- v. Mixed Race (Heritage/countries: _____)
- w. Other Latino (Country: _____)
- x. European (Heritage/Countries: _____)
- y. Other Middle Eastern: (Country: _____)
- z. Other heritage:

3. My biological sex was prescribed at birth as:

- a. Male
- b. Female
- c. Intersex
- d. Other: _____

4. My age group is:

- a. 18-30
- b. 30-40
- c. 40-50
- d. 50-60
- e. 60-70
- f. 70-80
- g. Older than 80

5. In terms of sexual identity, I am:

- a. Lesbian
- b. Gay
- c. Bisexual
- d. Queer
- e. Heterosexual
- f. Questioning
- g. Asexual
- h. Pansexual
- i. Other: _____

6. My religion/faith/spirituality is best described as

- a. Atheism
- b. Agnosticism
- c. Christianity
- d. Hinduism

- e. Universalism
- f. Sikhism
- g. Buddhism
- h. Ba'hai
- i. Wiccan
- j. Spiritual Synchronism
- k. Indigenous/Native/Tribal (Specify: _____)
- l. Confucianism
- m. Jainism
- n. Judaism
- o. Islam
- p. Rastafarianism
- q. Other: _____

7. In terms of the stage of your gender transition, please circle ALL that apply:

- a. Have received counseling related to my transition
- b. Have undergone hormone therapy related to my transition
- c. Pass in public (Specify how often: _____)
- d. Have undergone surgery related to my transition (Specify: _____)
- e. Plan to undergo surgery, but haven't yet (Specify: _____)
- f. Feel I am "fully transitioned"
- g. Don't plan to undergo hormone therapy or surgery as part of my transition

Use this space to elaborate on the stage of transition you are in:

8. I began to transition at age _____ .

Section 2: Quality of Life

9. I would describe my physical health as:

- a. Excellent
- b. Good
- c. Average
- d. Fair
- e. Poor

Use this space to elaborate on the state of your physical health:

10. I currently reside in: _____

11. I would describe my healthcare experiences related to my transition as:

- a. Excellent
- b. Good
- c. Average
- d. Fair
- e. Poor

Use this space to elaborate on your healthcare experiences related to your transition:

12. I would describe my employment status as:

- a. Unemployed
- b. Employed part-time
- c. Temporarily employed by AmeriCorps or a Service Organization
- d. Newly Unemployed (recently let go)
- e. Interning but not employed
- f. Other: _____

Use this space to elaborate on the details and circumstances of your employment situation:

13. In terms of housing, I have:

- a. A fixed residence
- b. Live with a friend, family member, or parent
- c. Live in a shelter
- d. Other: _____

14. In terms of income, I make:

- a. Less than \$10,000 a year
- b. \$10,000 - \$20,000 a year
- c. \$20,000 - \$30,000 a year
- d. \$30,000 - \$50,000 a year
- e. \$50,000 - \$70,000 a year
- f. \$70,000 - \$100,000 a year
- g. Upwards of \$100,000 a year (Provide a range: _____)

Use this space to share details and circumstances related to your income:

15. I would describe my mental health status as:

- a. Excellent
- b. Good
- c. Average
- d. Fair
- e. Poor

Use this space to elaborate on your mental health status. How would you describe your overall level of enjoyment of life? Have you dealt with depression or attempted suicide? Any details you would be willing to share would be useful to our study.

16. My partner/marital status is:

- a. I am married
- b. I am partnered (including within non-monogamous relationship models)
- c. I am single
- d. Other: _____

17. In terms of education, I have:

- a. No diploma or degree
- b. A high school diploma
- c. An associates or trade degree
- d. A bachelors degree
- e. A master's degree
- f. A terminal degree

18. I would describe my financial status as:

- a. Excellent
- b. Good
- c. Average
- d. Fair
- e. Poor

Details related to your financial status may be useful for the purpose of our study. Are you in debt? What is your debt from? Have you ever filed for bankruptcy? How much are you in debt? We appreciate any details you might share.

19. I would describe the level of emotional support I've received from family and partners during my transition as:

- a. Very High
- b. High
- c. Average
- d. Fair
- e. Low

Please share your experience related to the level of emotional support you've received from family and partners during your transition:

20. I would describe the level of emotional support I've received from friends and the community at large during my transition as:

- a. Very High
- b. High
- c. Average
- d. Fair
- e. Low

Please share your experience related to the level of emotional support you've received from your friends and your community during your transition:

21. The quality of medical care I have received during my transition has been:

- a. Excellent
- b. Good
- c. Average
- d. Fair
- e. Poor

Please share your experience related to the quality of medical care you've received during your transition.

22. My HIV status is:

- a. Positive
- b. Negative
- c. Unsure/haven't been tested

23. I engage in drug use

- a. Very frequently
- b. Often
- c. Sometimes
- d. Infrequently
- e. Never

24. I engage in alcohol use

- a. Very frequently
- b. Often
- c. Sometimes
- d. Infrequently
- e. Never

25. I engage in sexual risk behaviors such as unprotected sex with strangers:

- a. Very frequently
- b. Often
- c. Sometimes
- d. Infrequently
- e. Never

Section 3: Discrimination Experiences

26. Have you ever been displaced or disowned because of your gender identity? Please share any related or relevant experiences.

27. Have you been mistreated on the job or fired because of your gender identity? Please share any related or relevant experiences.

28. Have you been denied healthcare, made to feel uncomfortable, or mistreated by a healthcare provider related to your gender identity? Please share any related or relevant experiences.

29. Have you been homeless or experienced housing instability related or connected to your gender identity? Please share any relevant or related experiences.

30. Have you experienced any physical, verbal, or sexual bullying, harassment, or abuse related or connected to your gender identity? Please share any relevant or related experiences.

31. Have you experienced any other forms or instances of prejudice, discrimination, harassment, bullying, or mistreatment related or connected to your gender identity? Please share any relevant or related experiences.

Thank you for participating in this study, completed anonymously through Google Forms. Please feel free to attach or include additional information related to any of the subjects of this survey. This survey instrument was developed by the primary investigator and constitutes her original work.