The Demographics of the Transgender Population

16

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Introduction

We want to stress at the outset of this chapter that the task of representing the transgender population is nothing if not daunting. The difficulties, as we see them, stem from two main sources: (1) though a general "trans" sensibility exists in both the United States and worldwide, there are currently few measurable and/or standardized criteria (e.g. physical, social, political, etc.) regarding what might or *should* constitute a transgender person; and (2) problems with locating and accounting for this population are compounded by the relative invisibility through which many transgender individuals exist in their daily lives. Marginalized by political, religious, legal, medical, and other cultural institutions, transgender persons encounter levels of discrimination that range from simple misapprehension and exclusion by an uneducated public, to explicit acts of sexual and physical violence (Mizock and Lewis 2008; Richmond et al. 2012). Indeed, many in what is often referred to as the mainstream, including transgender individuals, are first exposed to the idea of "transgender" through media that sensationalize and misrepresent the issues most salient for this population.

In this chapter, we attempt to correct, as well as explain the bases for many of the unfounded and problematic assumptions made about transgender persons in the contemporary U.S. Transgender politics and visibility in the U.S. are uniquely, almost contradictorily, contoured: at the same time that celebrity culture brings the faces of RuPaul and Chaz Bono into the homes of many Americans, private and market-driven health insurance (which, outside the context of the Affordable Care Act, is tied to employment and/or marital status) leaves many transgender persons without adequate resources to manage their general medical and transition needs. In contrast, the single-payer healthcare systems of Northern Europe and Canada have covered these services for several decades, allowing researchers in these countries to produce some of the most useful and accurate data regarding this population. In line with Valentine (2007), we suggest that such disparities index how the category *transgender* is imagined by various communities, and that an understanding of these local inflections is a crucial element in grasping the contemporary significance of a transgender identity.

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A.K. Baumle (ed.), *International Handbook on the Demography of Sexuality*, International Handbooks of Population 5, DOI 10.1007/978-94-007-5512-3_16,

Transgender identity has long been characterized as sexually or socially deviant; it has also been labeled a "natural diversity in human sexual formation."[1] Theories about trans identity and practices have ranged from nineteenth century ideas about inherited and familial degeneracy to decidedly twenty-first century neurophysiological accounts of brain and hormonal sex differentiation in utero. Demographic populations are only as stable as the socially recognized variables through which they are defined, some of which are more fixed (e.g. chronological age) than others (e.g., "race"). Winters and Conway (2011) argue that "minorities do not count until they are counted." Because the trans population has long been (mis)recognized in terms of sexual orientation, rather than the bodily incongruity that dominates many contemporary trans narratives, we argue that the population itself is in an almost constant state of redefinition and refinement.[2] This assertion is meant to discount neither the importance nor utility of a demographic overview of the trans population; rather, we wish to underscore that the population under review is one that is broadly in transition, and that any relevant facts about it should be interpreted in socially and historically-specific terms.

A Guide to Terms

In their work *Same-Sex Partners: The Social Demography of Sexual Orientation*, Baumle et al. (2009) begin their analysis by asking readers to consider what it would require to "bring the study of sexuality more into the mainstream of demography" (3). Noting that "the field of sociology has long suffered from a lack of focus on issues of sexuality," (3) the authors argue that it is high time for this to change, and for sex and sexuality to occupy more prominent roles in contemporary demographic analyses. Sexual orientation, they continue, is not only a factor that can influence one of demography's core processes (i.e., fertility—via behavioral practices), but should also be understood as "an important personal characteristic that can shape and inform [other] demographic processes" (4), such as residential patterns and income levels.

Demographers who agree with these authors recognize both the importance of and the difficulties inherent in collecting meaningful data about groups often labeled as sexual "minorities." Indeed, when Laumann and colleagues (1994) sought, over a decade ago, to include homosexuality in their volume called the *The Social Organization of Sexuality*, they grappled explicitly with the challenges of accurately representing a group whose identity was—at least partially—constructed through specific cultural and historical context(s):

> To quantify or count as something requires unambiguous definition of the phenomenon in question. […] When people ask how many gays there are, they assume that everyone knows exactly what is meant. [But h]istorians and anthropologists have shown that homosexuality as a category describing same-gender sexual desire and behavior is a relatively recent phenomenon […] peculiar to the West. [… E]ven within contemporary Western societies, one must ask whether this question refers to same-gender behavior, desire, self-definition, identification, or some combination of these elements. In asking the question, most people treat homosexuality as such a distinctive category that it is as if all these elements must go together. On reflection, it is obvious that this is not true. (290)

In this chapter, we argue that what was true for homosexuality in the mid-1990s is true for transgenderism almost two decades later. That is, given both the socially constructed—and thereby unstable—nature of a category like transgender, as well as the intensely material ways through which transgender individuals live their identity (e.g. restroom challenges, hormonal side effects), demographers interested in researching this population face a peculiar set of analytical and descriptive challenges. Whether and to what extent transgender constitutes the type of "distinctive category" posited by Laumann and colleagues about which knowledge can be accurately generated

[1] http://www.truecolours.org.au/publications/development.html

[2] To this end, the American Psychological Association is set to release its fifth version of the Diagnostic and Statistical Manual of Mental Disorders in 2013, in which the diagnosis Gender Identity Disorder will more than likely be renamed Gender Dysphoria. See the Mental Health section for further discussion of this issue.

and about whom demographic statistics and claims can be reliably asserted, are questions taken up in the following section.

Trans as Gender Identity

A key issue facing the transgender population is nomenclature, i.e., which terms or categories best reflect the population itself (ALGBTIC 2009; Bockting and Coleman 1991; Green 2004; NCTE 2009). Since 1949, the word *transsexual* has referred to individuals who had a clear sense of being "[born] in the wrong body" (Meyerowitz 2004). More specifically, a *transsexual* lives full-time in a cross-gender social role: a person assigned male at birth that lives full time as female would be identified as a male to female (MTF) transsexual, while a birth-assigned female that lives full time as male would be identified as a female to male (FTM) transsexual. Represented by celebrities such as Renee Richards, Christine Jorgensen, and Chaz Bono, this is an identity characterized by beliefs about body-mind incongruity and (most typically) a desire to have one's body align with one's gender identity or *reassigned* into the other sex.

The term *transgender* has become increasingly popular in the past decade and reflects a less restrictive or binarized set of beliefs (Green 2004; Valentine 2007). More specifically, *transgender* describes persons who do not feel like they fit into a dichotomous sex structure through which they are identified as male or female. Individuals in this category may feel as if they are in the wrong gender, but this perception may not correlate with a desire for surgical or hormonal reassignment. For example, people who were assigned female at birth who enjoy stereotypically masculine (per their cultural norms) attire, activities, and presentation may identify as transgender because their gendered preferences and expression are incongruent with the cultural expectations of females. While these female assigned people are gender non-conforming, they may identify as transgender without feeling trapped in or wanting to modify their bodies. A *transgender* person may dress, behave or self-identify anywhere along a culturally defined gender *spectrum,* i.e., a non-binarized and three-dimensional palette of gender and sex expression. The primary difference between the two is often described in terms of the restrictiveness of the category *transsexual,* which implies that a person desires body modification and to be socially recognized as the "other" gender. Indeed, after physically transitioning, many transsexual people consider themselves men or women and no longer identify as transsexuals (Bolin 1988; Devor 1993; Newfield et al. 2006).

Theories about the etiology of transgender and transsexual identity are numerous. Many of the most recent focus on "brain sex" or "brain gender," i.e., specific anatomical sites and/or brain-regulated hormonal processes that "sex" a person as either male or female (Gooren 2006; Hines 2004; Kruijver et al. 2000; Moir and Jessel 1989; Zhou et al. 1995). Although there has been a marked increase of research in this area within the past decade, there is a range of opinion about its explanatory power. Some of this disagreement extends to terminology. Research has thus far failed to attribute gay and lesbian identities and/or behaviors to biological causes (Frankowski 2004; Herrn 1995), and many in the transgender community interpret their experience along the same lines, i.e., as a complicated and overdetermined mix of biological, social, psychological, hormonal, and possibly neuro-anatomical factors. Others, however, believe that theories of "brain sex"—that anatomical sex differentiation can occur along separate brain and genital trajectories—are more resonant with the experience of transgender persons. According to this argument, gender identity is (biologically) located in the brain rather than the genitalia (Rametti et al. 2011), and altering one's body and/or lifestyle to more properly align with this sex should not be understood in terms of a transition, but rather an affirmation. This at times contentious dynamic within the community itself has led one activist and researcher to label the terms MTF and FTM "prejudiced, inaccurate and genitocentric"[3] and

[3] http://www.truecolours.org.au/publications/ypwts.html. See also: http://www.annelawrence.com/brain-sex_critique.html for a critique of the brain-sex theory.

to propose acronyms that better reflect this approach: *affirmed females* (AF) and *affirmed males* (AM) for individuals whose brains are sexed female and male, respectively (Fenway Health 2010). A leading adolescent medicine expert suggests referring to transgender youth as *asserted males* and *asserted females* because *asserted* does not imply that someone else has to affirm their gender identity for it to be authentic (Olson, personal communication, 2012). Notably, these terms could include women and men whose genitals align with their brain and who choose to stay that way; these individuals are often referred to by gender activists, however, as *cisgender* persons (i.e., non-transgender persons). *Cis* women and *cis* men (the latin *cis* means "same") live in and identify with the same body in which they were born.

Many transsexuals feel strongly about making a commitment to a gender identity, where transitioning marks a clear move across, i.e., *from* one gender *to* the other (Namaste 2000). For these individuals, there is an unambiguous divide between men and women, one dictated by anatomy, hormones and an overall "sense of self." For others, the line between genders is less clear, and many may not require genital surgery, hormones, or any changes in clothing, partner choice, occupation, or social role(s) in order to feel as if they are living in the gender with which they most closely align. For others still, the line between genders is not a line at all. Rather, the binary between male and female is illusory and, for them, playing with sex and gender is a creative, political, or rebellious way to express that on a daily basis (Bornstein 1994; Feinberg 1997; Nestle et al. 2002). Importantly, it is not only trans people who believe in deconstructing this binary; many cisgender and transgender people live the details of their lives in ways that purposely and consciously challenge the often restrictive categories of male and female. A person with an active disinvestment in the gender binary who does not identify as either "male" or "female" per say might call themselves *genderqueer* in order to indicate that what is getting "queered" is the gender binary itself, not the sexual orientation of the person in question.

Also of importance is that none of these terms have historically included individuals born with bodies that could not be easily categorized as male or female by parents and/or physicians. In fact, these people have been historically excluded from the DSM-IV-TR diagnosis of Gender Identity Disorder in order to separate the "typically-sexed" transgender population from those born with more "ambiguous" sex characteristics (APA 2000). This latter group, currently described as *intersex,* may be surgically "assigned" a single sex shortly after birth (Kohler et al. 2012); some grow up to reject that assigned sex, however, owing to some of the same factors that transgender persons cite: an incongruence between chromosomal, hormonal, anatomical, and/or affective experiences of their sexed and gendered selves. Some intersex persons prefer to be included as *trans*, while others would rather distance themselves from this population. Again, this population remains relatively unquantified, despite a decade-old uptick in both writing and research about intersex persons. This research includes important works by critical biologist Anne Fausto-Sterling, who attempted to enumerate and quantify five "sexes" in 1993 (though she has since revised this taxonomy), as well as historian Alice Dreger, whose book *Hermaphrodites and the Medical Invention of Sex* (2000) has been praised for bringing the voices of intersex individuals and clinicians into critical dialogue with one another. Suzanne Kessler (1990, 1998) and Katrina Karkazis (2008) have each conducted long-term ethnographic research with families and clinicians and intersex activists, including Cheryl Chase (1998, 2003) and Riki Wilchins (1997, 2004) have written scores of popular, clinical, and scholarly publications on the subject.

There are divisions among clinicians about which disorders of sexual development/differentiation should be counted as *intersex,* and most surgeons, wanting to "leave well enough alone," have neglected to conduct long-term follow-up research with the individuals they have assigned at birth (Karkazis 2008). As with trans issues, word choice and terminology are profoundly political within this population, reflecting dynamic

notions of identity informed by new information, the perfection of surgical techniques, and shifts in social attitudes (Dreger et al. 2005). Terms that have been used thus far—hermaphrodite, ambiguous genitalia, intersex, and disorders of sexual development/differentiation (DSD)—do not capture the complexity of many of these individuals' identities. Many who feel that their surgery was performed improperly have become politically active and have vociferously called for an end to what they understand as genital mutilation. There are also adults living far more quietly in their sex of assignment, to varying degrees of contentment, who remain invisible and uncounted. Many of these individuals would consider themselves to have transitioned if their gender identity is different from the sex they were assigned. Many, perhaps because of the acute way that their own bodies signal the inadequacy of the gender binary, choose to live in terms closer to *genderqueer* (Nestle et al. 2002). What is most relevant here is that regardless of ideological positioning, this population experiences many of the same issues as the transgender population under consideration in this chapter.

In order to capture the largest population of gender variant individuals, we will use the broader term *trans* to refer to persons who wish to be socially recognized as a gender distinct from their assigned sex, with or without the desire for body modification. For reasons of order and containment, we will limit our presentation of data and discussion to populations—however inconsistently defined—that have either transitioned from one gender to another or who present with a desire to do so. Much of what is both exciting and challenging to document is the shifting nature of the population itself; there is currently no uniform definition of what it means to be *transgender*, partly because the various communities prefer it this way. Research that purports to represent a *transsexual* or *transgender* group or population should be critically evaluated for inclusion and exclusion criteria (surgery, hormones, lifestyle changes, social and legal identities) before conclusions are drawn from the results or generalizations are made. Indeed, it is likely that by the time this chapter goes to press, another term or set of terms will have emerged, rendering those employed here irrelevant or even politically incorrect!

Sexual Orientation and Sexual Behavior

One of the more unfortunate ways that trans people are publicly imagined are as objects of erotic curiosity and gratification, a subculture organized around transgressive and fetishistic sexual behaviors; this reality is underscored by any Google search, including images, of the word "transgender." However, trans identity does not correlate with any particular primary object(s) of desire. Rather, a trans identity reflects the *gender* that a person feels, lives, and wishes to express, including all of its non-sexual aspects. Although elements of one's gender are influenced by one's object(s) of desire, gender scholars are careful to stress that conflations of gender identity and sexual orientation fix, rather than unsettle, heteronormative assumptions about sex and sexuality (Halberstam 1998; Karkazis 2008). Contemporary attitudes about homosexuality reflect increasingly tolerant scholarly and social discourses, both of which include the understanding that same-sex desire does not inevitably correlate neatly with dominant definitions of masculine or feminine. It is important, therefore, that we disrupt beliefs that even some trans people might have about *why* they are in the wrong body/sex/gender: were a same-sex attraction the *only* criteria leading people to believe they were trans, we might caution them to think their desire through more carefully, stressing the inadequacy of that attraction as the sole criteria for changing genders. In other words, in order to most adequately apprehend the bodily *and* affective experiences of trans people, including their varied approaches to change via surgical, hormonal and behavioral means, we must de-naturalize many of the habitual assumptions made about the relationship between gender identity and any particular "sexuality."

Carefully separating sexual orientation from gender identity as well as from physical sex draws attention to the ways that each of these domains is socially constructed, or at least informed

(Bornstein 1994; Denny and Green 1996; Diamond 2001). This is a key issue for many individuals who want to make a socially recognized gender transition that is unrelated to her or his object(s) of sexual desire; a person assigned female at birth who transitions to male may have male, female, trans, all, or no sets of these people as sexual partners. Moreover, labeling inconsistencies complicate the scientific literature because early research frequently used birth-assigned sex rather than current gender identity as the basis for assigning a sexual orientation to transsexuals. For example in one study, FTMs who were attracted to women were labeled homosexual and in another, more recent, study, FTMs who were attracted to men were labeled homosexual (Bockting et al. 2009; Chivers and Bailey 2000). This presents a problem in discussing research because sexual orientation labels, which are often organized around birth sex, are frequently more complex and nuanced with the transgender population, rendering any conclusions about the "sexual orientation" of *any* trans person questionable at best. FTMs who identify as men (and no longer as trans men) and who are attracted to males may identify as "homosexual;" whereas male-attracted FTMs who may be somewhat earlier in the transition process, or who still identify strongly with a trans component to their male identity, may identify as "queer" or as a "tranny fag" (Pardo 2008; Valentine 2007).

At least part of this confusion can be attributed to the fact that the 4th of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), published in 2000 by the American Psychiatric Association, classified Gender Identity Disorder (GID) in terms of sexual attractions, despite a growing body of research to the contrary (APA 2000; Coleman et al. 1993; Meier et al. 2013; Rachlin 1999). (Much of this research has been conducted by trans and known trans-ally researchers, an epistemic shift that should not be overlooked; we will return to this point below). As the ultimate arbiter of psychiatric and normalizing categories, the DSM produces knowledge around which individuals and groups are encouraged to conform, and through which many of us come to understand specific populations. This authoritative discourse finds its way into the general population, leading many trans individuals—and their sexual partners—to worry unnecessarily about the success or stability of their transition if they find their partner choices changing. By making sexual orientation part of its diagnostic specification for GID, the DSM-IV-TR conflated two elements of experiential identity that both trans activists and gender scholars endeavor to keep distinct. For these groups, the more important questions to pursue involve the ways that sexual orientation and gender identity intersect not only with each other, but also with other aspects of identity, including race/ethnicity, socioeconomic status, and education. Not only has recent research demonstrated that, at least for many cis women and trans men, sexual orientation is far more fluid and shifting than previous studies have reported (Diamond 2008; Meier et al. 2013), but also that the lived experience of a "gendered sexuality" is far more complex and varied than criteria-based profiles can adequately represent.

Further, research attempting to examine the psychological differences between trans people who reported differing sexual attractions (to females, to males, to both, to neither) has produced mixed results (Lawrence 2010a, b; Meier et al. 2013; Nuttbrock et al. 2010). The World Professional Association for Transgender Health, Inc. (WPATH), formerly the Harry Benjamin International Gender Dysphoria Association, issued a response to the proposed DSM-5 GID replacement disorder Gender Dysphoria (De Cuypere et al. 2010). The WPATH committee stated that they supported the removal of sexual attraction specifiers as Gender Dysphoria criteria, as sexual identity is irrelevant to a distress-focused disorder. The DSM-5 will be published in 2013 and its Gender Dysphoria diagnosis will not have sexual attraction specifiers. It is anticipated that clinicians will have to specify whether the patient is intersex. Unfortunately many of the non-medically trained clinicians who use the DSM for diagnostic purposes including psychologists, therapists, and social workers, may not be not able to determine this.

It is reasonable and important to note that trans individuals engage in the same varieties of

sexual behaviors as do heterosexual and LGB (lesbian, gay, bisexual) individuals; this can include kissing, manual and oral stimulation of the genitalia, vaginal and anal penetration, frottage, mutual masturbation, phone or cybersex, watching or performing in sexually explicit media, BDSM practices, a variety of what are referred to as "paraphilias," sex work, partial/total celibacy, or abstention from sexual activity all together (Bauer et al. 2012; Meier et al. 2010a). What might be considered unique about this population is that its behavior often disrupts assumptions about the relationship between genitals and gender. Though many trans men (FTMs) employ strap-on dildos or other penetration aides, many others do not and, in fact, many trans men incorporate the penetration and stimulation of their own vaginas and vulvas into their sexual behavior (Bauer et al. 2012; Meier et al. 2010a). Similarly, many trans women enjoy penetrating their partner(s) and/or do not desire vaginal penetration even if they have gone through surgical "reassignment." These genital-gender incongruencies can be confusing to uninformed healthcare providers or other well-meaning individuals, leading to awkward and embarrassing exchanges or even denied access to healthcare when, for example, a trans man presents at a clinic for vaginal discharge or an abortion.

Baumle et al. (2009) note that sociology has typically attended to "sexuality" via the ways that it interferes with the traditional demographic category of fertility; that is, homosexual behavior and sexually transmitted infections become categories of analytical interest because of the effects that they have on reproduction. This emphasis, they argue, forces us to think about sexual orientation as a set of behaviors rather than an identity (3–4). Though we have used the previous section to "complicate" the stability of such an identity when it comes to the category transgender, we stress that the remainder of the chapter takes such a category at (relative) face value. The following discussions of prevalence, medical and mental health, family and relationships, discrimination, and work issues are all grounded in the real-life experiences of individuals who are seeking to or have already "transitioned" to the best of their ability. Though, again, we believe that the contemporary transgender experience resonates with Laumann and colleagues' description of homosexuality, i.e., as "a multidimensional phenomenon that has manifold meanings and interpretations" (1994: 301), we bracket the open-ended nature of the category for the remainder of the chapter in order to offer the most useful and up-to-date information possible.

Prevalence

In general, we might think about prevalence in two ways, either as: (a) a snapshot that can answer questions such as: How visible is a particular population or identity-based group of individuals? How likely are members of a society to encounter trans individuals in their daily lives or believe that they are "real," possibly even a part of their existing world?; and (b) demographic prevalence that is driven by statistics on a particular set of variables in a population.

Snapshot Prevalence

Thomas Beatie made headlines in 2008 when he was popularly dubbed "the pregnant man."[4] Beatie, a Filipino-American former beauty queen, posed for photographs, was interviewed by Oprah, and was featured in a number of print and web-based media during the months of his pregnancies providing a particular kind of "face" to the trans man population. As we have noted, Beatie's body breaks with the conventions of a *transsexual*, but the combination of his male gender identity and (procreative) female reproductive organs is consistent with the category of *transgender* with which we are working in this chapter.

[4] Though perhaps the first to go public, Beatie was not the first trans man to become pregnant. Beatie has since had his second and third babies and is in the process of divorcing his ex-partner who is a cis woman. See: http://www.dailymail.co.uk/femail/article-2197581/Worlds-pregnant-man-Thomas-Beatie-finds-love-prepared-conceive-FOURTH-time-new-lover-cant.html

Media stars like Oprah have the power to redefine and recontextualize marginal populations; a televised interview with someone like Beatie can provide a cultural legitimacy that is unavailable through (previously) popular discourse. The 20/20 production of "My Secret Self," featuring Barbara Walters exploring the lives of transgender children, had a similar effect in 2007. Sensitively produced, the program resonated throughout much of the trans community and continues to be used as a resource in public relations, education, and training efforts. Though this chapter will not deal extensively with transgender children, it is worth mentioning that there may be an increasing prevalence of GID among younger people, including children (Möller et al. 2009; Reed et al. 2009; Rosin 2008; Zucker et al. 2008). Studies of young children find that parents report that 0.5 to 1.4% of birth assigned male children and 0.6 to 2.0% of birth assigned female children wish to be the other gender (Verhulst et al. 1997; Yu 2009). Internationally, between 0.7 to 0.9% of birth assigned male college students and 2.2 to 2.9% of birth assigned female college students report that they wish they were the other gender (Chi in preparation; Lai et al. 2010 as cited in Winters and Conway 2011). Zucker et al. (2008) report that their number of referrals of children with GID has nearly tripled from 2000 to 2004. It still remains to be seen, however, whether that increase is: (a) real; (b) related to greater social tolerance and visibility; or (c) causally connected to other biocultural events (e.g., industrial pollutants and endocrine disruptors) through which embryological brain and genital development is being affected.

For reality-TV fans, entertainer RuPaul is the face of the trans population, and his MTV-produced show *Drag Race* has a loyal and diverse audience (Stanley 2009; Wieselman 2010); for political aficionados, it is Amanda Simpson, the Senior Technical Advisor to the Department of Commerce, and the nation's first transgender presidential appointee.[5] For economists, it is Deirdre (formerly Donald) McCloskey, an internationally renowned economist and University of Illinois professor who published a memoir about her very public transition in 1999.[6] And for the parents of young children, it is the availability of a book called *10,000 Dresses* (Ewert 2008), which chronicles a transgender girl's struggle to be recognized by her family.

Though much of this media celebrity, along with the popularity of trans-specific procedures on surgical reality shows, might cater to the more prurient interests of the general public, many members of the trans population take comfort in any measure of public recognition that does not actively advance discriminatory attitudes or behaviors. Transsexual, transgender, and trans ally scholars, activists, and researchers have also begun to take greater control over how the trans community is represented by conducting and disseminating their own research and media, aided by the inception of *The International Journal of Transgenderism* in 1997.

Our purpose in providing this "snapshot" overview is to provide a social and representational context to the prevalence data in the next section. Though we do not suggest that there is any particular correlation between the recent visibility of the trans population and the numbers that follow, we do encourage the reader to use both kinds of data in their own attempts to better understand the populations under consideration here.

Demographic Prevalence

Difficulties with measuring the trans population stem from the definitional dilemmas that we have discussed thus far. Though numerous researchers have reported prevalence statistics, they must be cited with caution because of the inconsistency with which "transsexual" and "transgender" have historically been defined. Prevalence estimates have traditionally come from gender clinics, where patients have been: (a) seeking body and hormonal modifications not necessarily sought by *all* trans-identified people; (b) compelled to

[5] Appointed by Barack Obama in January, 2010.

[6] *Crossing: A Memoir*, University of Chicago Press.

identify in a particular way in order to access the clinic services offered (van Kesteren et al. 1996; Weitze and Osburg 1996). Compounding the second problem are the verbal commitments to a sexual orientation that some of these patients have had to make in order to either secure services or be considered to have transitioned "successfully" (Lev 2005). Moreover, the personal and professional investments made by individual researchers in defining this population often play a significant role in their inclusion/exclusion criteria. In other words, because the community itself remains divided as to the "nature" of a trans-identity—its relationship to "brain sex," culturally constructed gender roles, and homosexuality, for example—research conducted among this population reflects the multiple lenses through which transgender individuals are understood. Indeed, at least one researcher has suggested that most trans-children are cis and homosexual, and that behaviors consistent with GID are the child's way of "coming out of the closet" (Zucker et al. 2008).

The prevalence data most frequently cited come from a gender clinic in the Netherlands and demonstrate that 1 in 11,000 (.009%) persons are MTF, and 1 in 30,400 (.0032%) are FTM (van Kesteren et al. 1996). A recent study from Singapore found 1 in 2,900 (.034%) MTFs and 1 in 8,300 (.012%) FTMs, while a study in Belgium found 1 in 12,900 (.0077%) MTFs and 1 in 33,800 (.0029%) FTMs (Winter et al. 2009). The American Psychiatric Association, using GID criteria, suggested that MTFs had a 1 in 30,000 (.0077%) prevalence rate, while FTMs were 1 in 100,000 (.0029%) (APA 2000). In contrast, another investigator suggests that if inclusion criteria were broad enough to cover everyone on the transgender identity spectrum (e.g., cross dressers with no desire for body modifications, intersex persons, genderqueer persons, masculine females, feminine males, etc.), we would find 1 in 2,000 (.05%) people to be trans (Conway 2002). Finally, researchers presenting at an annual transgender conference in 2007 estimated that "recent incidence data and alternative methods for estimating the prevalence of transsexualism [sic] […] indicate that the lower bound on the prevalence […] is at least 1: 500 [for all combined], and possibly higher."[7] A research brief from the Williams Institute estimates that there are around 700,000 trans people in the U.S. (0.3% of the population; Gates 2011). See Table 16.1 for a summary of prevalence estimates.

Although still significantly smaller, the 1 in 500 (0.2%) ratio comes closest to the estimate provided by the U.S.-based National Transgender Advocacy Coalition: that 2–3% of the (U.S.) population is transgender, some of whom overlap with the lesbian, gay, or bisexual (LGB) population and many that do not. This overlap is notable because it indexes the difficulty in neatly classifying the trans population into categories of sexual orientation—how the person and/or researcher defines LGB in the context of a trans identity will determine the manner in which the prevalence rate will accordingly shift. In Iran, this articulation is even more intriguing. Though it is currently illegal to be openly LGB in Iran, it is legal and, to a degree, socially acceptable to undergo gender transition. This has led to Iran having one of the highest known "transgender" prevalence rates in the world, somewhere between .12 and .18% of the population (MTF and FTM combined) and it is likely that many of these individuals would not identify as trans in other geopolitical contexts (SAFRA 2009). Based on their review of trans prevalence literature, Winters and Conway (2011) estimate that there are over 15 million trans people in the world.

These prevalence estimates are useful to a degree as they repeatedly demonstrate that vastly greater numbers of birth-assigned men appear to transition to another gender than do birth-assigned women (with the exception of Poland, Sweden, Iran and Japan) and that the overall percentage of the trans population across geographical areas is typically less than 1% of the population. The difference between these small estimates, however, and those larger estimates cited by Conway and others, point to the possible

[7] http://www.truecolours.org.au/publications/ypwts.html#15. Paper presented at the WPATH 20th International Symposium, Chicago, Illinois, September 5–8, 2007.

Table 16.1 The prevalence of transsexualism

Country	Year reported	Incidence (per 100,000 age 15 or above)	Total	MTF	FTM	MTF:FTM	Method	Reference
Australia	1981	4.9		1 in 24,000	1 in 150,000	6.1 to 1	Reports from psychiatrists on transsexual patients seen from 1976-1978	Ross et al. (1981)
Belgium	2007	10.7		1 in 12,900	1 in 33,800	2.6 to 1	Reports from plastic surgeons and gender teams on trans-sexual patients seen from 1985 to 2003	De Cuypere et al. (2007)
Germany	1996	2.1		1 in 14,400	1 in 33,200	2.3 to 1	Data from German courts regarding legal name and sex changes from 1981 to 1990	Weitze and Osburg (1996)
India	2009	167		1 in 600	Not available	Not available	Community estimate	Winter (2009)
Iran	2009	72		1 in 555	1 in 833	1.5 to 1	Community estimates	SAFRA (2009)
Iran	2009	45.5	1 in 2,200 to 3,300	Not available	Not available	Not available	Clinic studies	Winter (2009)
Iran	2010	8	1 in 13,000	Not available	Not available	Not available	Clinic based data	Alizadeh (2010)
Iran	2011	1.4	1 in 141,000	1 in 145,000	1 in 136,000	1 to 1.1	Reports on GID diagnoses from the Tehran Psychiatric Institute from 2002 to 2009	Ahmadzad-Asl et al. (2011)
Ireland	1982	1.9	1 in 52,000	1 in 71,400	1 in 214,300	3 to 1	Gender clinic cases of GIDfor 14 years: 21 MTFs and 7 FTMs Calculated from author's North Ireland 1982 population estimate of 1,500,000	O'Gorman (1982)
Ireland	2006	1.4		1 in 84,400	1 in 542,500	6.4 to 1	Gender clinic cases of GID from 2000 to 2004: 45 MTFs and 7 FTMs. Calculated from Ireland's 2000 population estimate in 3,797,257	De Gascun et al. (2006)
Japan (Western)	2008	1.4		1 in 173,913	1 in 114,613	1 to 1.7	Gender clinic cases of GID from 1997 to 2005: 349 FTMs 230 MTFs. Calculated from the authors Western Japan population estimate 40,000,000	Okabe et al. (2008)

Malaysia	2001	500 (MTF only)	Not available	1 in 200	Not available	Not available	Community estimate	Jamaludin (2001)
Malaysia	2009	1,333	1 in 75 to 150	Not available	Not available	Not available	Community estimate	Winter (2009)
Netherlands	1993	11.7		1 in 11,900	1 in 30,400	2.6 to 1	Gender clinic cases with gender dysphoria from 1975 to 1993	Bakker et al. (1993)
New Zealand	2008	31.9		1 in 3,639	1 in 22,714	6.2 to 1	Passport data obtained from the New Zealand Passports Office	Veale (2008)
Poland	2000	0.26		1 in 1,692,000	1 in 497,700	1 to 3.4	Gender clinic data obtained from 1980 to 1998	Dulko and Imielinskia (2004), as reported in Herman-Jeglinska et al. (2002)
Scotland	1999	8.2		1 in 61,000	1 in 15,200	4 to 1	Data from general medical practices on patients with gender dysphoria	Wilson et al. (1999)
Singapore	1988	35.2		1 in 2,900	1 in 8,300	2.9 to 1	Cases from the Department of OB/GYN at the National University of Singapore and three private surgeons	Tsoi (1988)
Spain (Andalusia)	2006	16.8	1 in 5,954	1 in 9,685	1 in 15,456	1.9 to 1	Clinic study	Esteva et al. (2006)
Spain (Catalonia)	2006	6.83	1 in 14,632	1 in 21,031	1 in 48,096	2.6 to 1	Clinic study	Gómez-Gil et al. (2006)
Sweden	1996	0.17		1 in 1,008,400	1 in 1,411,700	1.4 to 1	Data from the Bureau of Social Welfare files from 1972 to 1992	Landen et al. (1996)
Taiwan	2009	97.1	1 in 1,030	Not available	Not available	Not available	Clinic studies	Winter (2009)
Thailand	2002	599 (MTF only)	Not available	1 in 167	Not available	Not available	Community estimate	Winter (2002)
Thailand	2009	333		1 in 300	Not available	Not available	Community estimate	Winter (2009)
United States (Massachusetts)	2011	476	1 in 214	Not available	Not available	Not available	Telephone health survey	Conron et al. (2012)
DSM-IV-TR	2000	4.3		1 in 30,000	1 in 100,000	3.3 to 1	Data from Europe and referrals	APA (2000)

limitations of these data and the definitional dilemmas discussed earlier. Sample sizes for these studies are often small, making it difficult to generalize the results, and since they typically come from gender identity clinics, they represent what many would call the narrowest end of the trans-identity spectrum (Horton 2008). It has also been suggested that many of these clinics have used coercive methods in order to recruit subjects, compelling hormone or surgery-seeking patients to define themselves in terms they might not otherwise in order to receive services (Lev 2005; Meyerowitz 2004). Indeed, in an ethnographic study conducted in New York City in the 1990s, Valentine (2007) found that many of the gender variant individuals that he came to know only identified as "transgender" after they were labeled as such by a social service or healthcare agency. It is difficult to know if such methods contribute to an over-representation of the population because of padded data or an under-representation, due to the subsequent avoidance of clinics by trans folks who learned to obtain services elsewhere (see section below on "Health and Healthcare"). There are also anecdotal data to suggest that many trans persons avoid research/gender clinics because they are asked to pay for the psychological assessments that are performed on them or do not want their transitioning related data to be used for research studies (Anonymous transgender patients, personal communication, 2009).

Some trans people who make a medical and social gender transition choose to not disclose their history, preferring to be perceived only as their asserted gender. Indeed, a portion of these individuals may have never identified as trans, leading them to sometimes be referred to as *stealth* (colloquially) or *non-disclosing* (Green 2004). Though for some, a stealth identity might be asserted as "I'm (just) a woman, not a trans woman," it might be more accurate to say that there are levels of disclosure—from people that completely disavow their past to people who simply do not make it public.

It is easy to see that numerous trans people are flying under the proverbial radar. One group that "avoids" gender clinics, and may therefore not be counted, are people without the financial resources to access body modification, psychotherapy, or the social programs through which many transgender people are located and quantified. Some of these people will pursue surgery and/or hormones in another country, online, or through an informal market, and through these channels may occasionally find their way to a researcher. But just as many will affirm their gender within quite limited means (e.g. shaving instead of waxing or electrolysis for the removal of body hair), a situation that may make it easier for them to "pass" in and out of a trans-identity when and if necessary (Valentine 2007). These sometimes invisible members of the trans community are one more reason why clinic-based prevalence estimates should be understood as limited underestimates. Moreover, the tenacious relationship between socioeconomic status (SES) and race/ethnicity means that the majority of transgender persons securing more permanent (and aesthetically acceptable) forms of body modification are white/Caucasian, leaving trans people of color and of limited economic means less visible to demographers but perhaps more visible to a public that easily perceives an incongruence. In an all-too-familiar vein, trans people of color often show up in data focused on HIV, substance abuse, sex work, and other risk factors associated with lower SES. Some researchers have critiqued this (often) uncritical pooling of "risk" factors (Boehmer 2002; Valentine 2007), as it is typically more connected to structural inequality than to any sex or gender-based identity. Clearly, much work remains to be done in finding methods that can most adequately represent the complexity of this population (Mikalson et al. 2012), as "our lack of knowledge about how to identify transgender respondents on general population surveys hinders efforts to improve the health and socioeconomic status of this marginalized community" (SMART 2009, p. iv).

The regularity with which trans women outnumber trans men in these estimates remains a compelling pattern, and one that remains insufficiently explained. One set of theories suggests that birth-assigned females transition less because there is greater social room in

which they can maneuver with more masculine behavior (e.g. clothing, occupation). Even these categories have their limits, however, and trans men have been increasingly articulate about both the difficulties and the rewards of making bodily changes that more fully secure their positions as men (Schilt and Connell 2007; Valentine 2007). Valentine has argued that this non-transitioning space in which "masculine" and other women navigate is unavailable to men and that this may partially explain why more birth-assigned men make the bodily commitment to affirming their female identities. In other words, Valentine suggests that there is no socially acceptable equivalent to the butch straight woman for men who wish to live a feminine identity that does not correlate with an LGB one. He concludes that gender "reassignment" may be the only way for men to gain access to this space. Confounding these more speculative theories, however, are compelling data from Poland that demonstrate a significantly higher rate of FTMs than MTFs (Herman-Jeglinska et al. 2002; Levy et al. 2003) than do data from the Netherlands and other reporting countries. And though explanatory models remain scarce, some researchers have long questioned MTF/FTM disparities and find the Polish data neither new nor surprising (Herman-Jeglinska et al. 2002; Hoenig and Kenna 1974). In fact, many researchers and clinicians believe that FTMs are more likely to "go under the radar," even from researchers, and therefore have been routinely underestimated in prevalence data (Green J, Meyer M, Schilt K, 2008–2010, personal communication).

Importantly, when trans researchers start measuring members of their own population, larger sample sizes are typically collected. Samples of trans people in research conducted by cis researchers have historically ranged from 1 to 100 (Van Borsel et al. 2000; Chivers and Bailey 2000; Cohen et al. 1997; Lothstein 1984), yet recent research by trans researchers produce data sets from 200 to over 1,000 (Davis and Meier, submitted; Dickey 2007, 2010; Meier et al. 2010a, 2013; Veale et al. 2008). Trans researchers tend to be more aware of the community's needs and potentially offensive language than even well-meaning cis researchers. Participants in the trans author's (of this chapter) thesis and dissertation research have consistently expressed relief that the study in which they are participating is being conducted by "one of us." Trans participants also have far less to lose when disclosing atypical gender-related desires if the research is not being conducted within the context of a gender clinic; this may lead to the collection of more accurate information. Lastly, because the trans community has a strong Internet presence, they are well connected and can refer many other trans people to studies that they deem "sensitive" and "worthwhile," whereas they may also warn others not to participate in studies not considered "safe."

Prevalence in the DSM-IV-TR Gender Identity Disorder (now Gender Dysphoria) and Children

The DSM presents yet another definitional challenge to establishing prevalence. One major concern that arises from the lack of a standardized definition for the term *transgender* is whether and how to include children and adolescents in this category. Because GID is the most measurable and longest running set of criteria related to being trans, there has been a significant degree of conflation between gender dysphoria and the category of transgender when these individuals are being assessed and evaluated. While a GID diagnosis exists for children and adolescents, experts have noted that many of those who meet the criteria for GID in childhood grow up to identify as LGB and not transgender (Wallien and Cohen-Kettenis 2008; Zucker et al. 2008). Further, many transgender people report that they were not aware of their transgender identity until adulthood or that they hid their gender non-conforming expressions and behavior from others due to shame and would not have met criteria for GID in childhood (Seil 2004). As such, using the criteria for GID in childhood for prevalence estimation of transgender children and adults is clearly limited.

The DSM is used to help researchers calculate the prevalence of mental disorders and it continues to carry a great deal of authority for researchers, clinicians, and insurance providers; this presents a major problem for many both in and outside of the transgender community who do not view a gender identity that is incongruent with one's birth-assigned sex as inherently disordered. Largely for this reason, the DSM has recently revised both the criteria and the nomenclature for GID and it will be re-named Gender Dysphoria. [8]

Currently, there are two leading schools of thought concerning how trans children should best be approached: (1) Ehrensaft's acceptance—based on Brill and Pepper's ideas of unconditional love and Ryan's model of Family Acceptance, this approach involves helping the child to be comfortable in his or her asserted gender identity (Brill and Pepper 2008; Ehrensaft 2011; Ryan et al. 2008); (2) change—based on Zucker's research, this involves attempting to change the gender non-conforming expression, roles, and preferences of the child (Dreger 2008; Rosin 2008). Supporters of the latter approach caution about the difficulty and cost of a transgender identity, arguing that being LGB is preferable.[9] In a study with children labeled as transgender, Wallien and Cohen-Kettenis (2008) found that the most common outcome of this childhood pattern is an LGB non-transgender identity.

Though the "disordered" language of the DSM has long been a target of criticism, some of it has been assuaged by the nomenclature and criteria-based revisions underway. For some, however, Gender Dysphoria continues to index a malady or discordance that the phrase "normal expression of gender variance" does not. Others have a categorical critique, and are concerned about GID's inclusion in a section (Sexual and Gender Identity Disorders) that includes pedophilia and other "paraphilias" such as voyeurism and fetishism. Gender Dysphoria is set to be placed in its own section in DSM-5. Further, many of the current criteria for children are written with what seem to be narrow interpretations of behavioral patterns. The pathologization of boys who avoid "rough and tumble play," for example, indexes a set of culturally-specific gendered stereotypes through which all kinds of "gendered" behavior can be misunderstood. Some critics, and not just transgender ones, go even farther and argue that the DSM cannot adequately represent mental or emotional disorders from the narrow perspective of the U.S., as it remains unclear whether the difficulties related to GID are intrinsic to persons with GID or whether they are the outcomes of feeling discriminated against, socially rejected, or stigmatization (APA 2009; Winters 2009).

Some see a DSM diagnosis as a possible path to legitimacy, awareness, protection in discrimination lawsuits, and greater insurance coverage, but this has been questioned as countries that now cover gender affirmation treatment often only do so if the patient agrees to a "full" complement of therapies (chest and genital surgery, hormones etc). The revisions to the GID diagnosis will be published in DSM-5 and will affect prevalence calculations for at least the next 10 years. Though it is too early to tell, with both U.S. healthcare reform and DSM revisions in the coming decade, it is possible that the relationship to a childhood or adult diagnosis of GID—and the prevalence rates derived from it—will look vastly different than they do now.

Social Complications and Context

There are multiple layers of social complications that make prevalence estimates challenging. Demographers attempting to count the number of people who legally change their gender should be aware of the procedures and barriers involved in this process. Those who are attempting to separate LGB and T persons for prevalence estimates may not realize the political ramifications of such a separation or the fact that many trans people identify with an LGB sexual orientation. Also, any prevalence estimate of this population must take

[8] The latest DSM will be its 5th revision, and a new name for gender dysphoria will constitute the "condition's" 3rd revision. It is worth noting here that homosexuality was a DSM-certified disorder until 1973 (Drescher 2009).

[9] J Cantor, 2009, personal communication.

into account the overwhelming rates of suicide among, and hate crimes against, trans people. We compile these complications here as a guide toward generating better estimates that are urgently needed in order to inform the policies and regulations that aid trans people in accessing medical, legal, and social recognition and services.

One way researchers are attempting to calculate the prevalence of trans people is by counting the number of people who have had their gender changed legally on identification documents (Bauer 2012; Veale 2008). Currently, the procedures through which an individual can legally change his or her name or gender vary widely, both within the U.S. and across other countries. In some U.S. states, individuals can simply check a box on a form in the Department of Public Safety, while other states require the individual to pay hundreds of dollars, stand before a judge, and present a psychological evaluation report or physician's letter endorsing their suitability for name/gender change (Transsexual Road Map 2010). Still other states do not allow one's gender to be legally changed without having undergone a specified complement of gender affirmation treatment, including chest and genital surgery. Further, a few jurisdictions simply refuse to recognize a gender change on a birth certificate, regardless of social or medical transitions. Demographers should also take note that once a trans person obtains a legal gender change on identification documents, they may be less likely to indicate that they are transgender on surveys, as they are socially recognized as their gender identity and may not wish to disclose their trans history. This may also be the case for those trans people (regardless of legal gender status) who do not identify their gender to be "transgender," but rather male or female.

Name change is an issue that relates directly to legal identification documents (passport, driver's license, birth certificate, social security card), all of which need to be congruent in a variety of situations, such as acquiring a bank loan, receiving one's inheritance, working for particular institutions, or receiving federal subsidies for education or housing. Gender change, while related to these issues, can also lead to charges of fraud. Numerous trans persons have had inheritances challenged by the children of a deceased spouse who argue that their parent was the victim of gender fraud (Bratter and Schilt 2009; Flynn 2001). To date, these cases are typically handled on a case by case basis, and no widespread legal precedent currently exists to protect trans individuals from these types of suspicion and exclusion. Finally, trans men may not attempt to obtain a gender marker correction to 'M' on their drivers license, as once they are legally recognized as male, they are commonly denied insurance claims for hysterectomies, pregnancy, and/or government funded student loans, as most have never applied for the draft. These complications, coupled with the fact that some trans people will never attempt to legally change their name and/or gender, complicate this method of prevalence estimation.

For some lawyers and legal scholars, trans issues are a unique opportunity to redefine and reconceptualize categories of personhood, rights and privileges. Some advocate for trans issues to be conceptualized within a framework of human rights, while others define the trans legal experience in terms of discrimination (Flynn 2001). Different legal conceptualizations of trans people have implications for prevalence calculations (e.g. should we estimate the number of LGBT people or LGB and T people?). Trans activists and the trans community itself are also multiply positioned, with some preferring to identify within the identity-based umbrella of "LGBT," and others who feel that, because a trans identity is not organized around sexual orientation, the "LGB" movement has little to offer in the way of political protection or advocacy and sometimes trans people even face trans-negativity within the LGB community (Currah et al. 2006). Indeed, this divide was brought into clear focus when the gay and lesbian-focused Human Rights Campaign (HRC) elected to exclude "trans" from their list of identities deserving of special protection against employment-based discrimination.[10]

[10] See especially Valentine (2007) for an excellent history of this episode. Though beyond the scope of the chapter, it is worth noting that some of the discourse surrounding this decision was related to the (formal) LGB political community's desire to appear to be as "normal" as possible, a move that some argue sacrificed allegiance with the trans community for mainstream social acceptability.

Another complexity concerning estimating the prevalence of the trans population is the incredibly high rates of suicide and homicide (See section below on "Population Health: Mental Health" for a more in-depth discussion of suicide and Table 16.5 for rates). Recent research has demonstrated that LGB youth and adults may be at significantly higher risk for suicide attempts than their heterosexual peers (King et al. 2008; Marshall et al. 2008), yet research on the prevalence of these problems within trans populations is rare. As many as 16–45% of trans individuals have attempted suicide (Bockting et al. 2005; Clements-Nolle et al. 2006; Grossman and D'Augelli 2007; Kenagy 2005; Meier et al. 2011; Xavier et al. 2005); it is unknown how many more have been successful. Lobato and colleagues (2002) found that, compared to heterosexual and gay cis individuals, trans individuals had higher rates of completed suicide attempts than any other group except for lesbians (Lobato et al. 2002).

Homicidal and non-fatal hate crimes also occur at high rates in the trans population (Marzullo and Libman 2009). An expert affiliated with the Harvey Milk Institute in San Francisco estimates that "transgender individuals living in America today have a 1 in 12 chance of being murdered." (Brown 1999). In contrast, the average person has about a 1 in 20,000 chance of being murdered (FBI 2009).[11] Taken together, this implies that trans people may be more than one and a half thousand times more likely to be murdered than cis people, a startling statistic that has obvious implications for attempting to quantify the trans population. From November 2011 to November 2012, the murders of over 265 trans people were reported, over 100 of them were trans women who were living in Brazil (TGEU 2013). As trans people are dying at higher than average rates due to suicide or homicide, overall prevalence numbers are thought to be a gross underestimate of the true prevalence.

[11] Based on the FBI's "Uniform Crimes Reports, Crime in the United States 2000," showing the murder rate of 5.5 people per 100,000.

Population Health Issues

For all the reasons outlined thus far, it has been challenging to collect data regarding trans-specific health care problems: representational categories dealing with this population have shifted, many trans people have been reluctant to participate in research, and there remains little to no consensus on the "biological" nature of a trans identity. What does exist, however, are a set of health problems related to transitioning itself, as well as a set of concerns among this population regarding access to affordable and adequate health care. This section will focus on the types of problems for which trans people most often seek trans-specific care (e.g., hormones, surgery), how clinicians can provide the most effective and the least discriminatory care possible (primary or specialized), as well as the vulnerabilities experienced by trans people whose access to health insurance is limited or compromised. Each of these variables can impact the health of the population as a whole.

An unfortunate number of healthcare providers have declined to provide care—comprehensive or episodic—to the trans population for reasons related to personal prejudice (Grant et al. 2010; Transgender Law Center 2004; Lambda Legal 2010). The National Transgender Discrimination Survey report on health and health care of over 7,000 trans respondents reported that 19% reported being refused care, 28% were harrassed in medical settings, and 50% reported having to teach their provider about trans care (Grant et al. 2010). An even greater number, many of whom deny any such feelings, remain uneducated (Obedin-Maliver et al. 2011) about trans-specific healthcare needs, arguing that either: (a) the relatively small size of the population precludes the likelihood that they will see trans patients in their practice; and/or (b) there are no special needs about which to learn. For the authors of this chapter, neither of these explanations is an acceptable alternative to keeping a medical practice open and referring (as appropriate) patients that go beyond a practitioner's level of expertise. Indeed, it

Table 16.2 Trans healthcare resources

Organization/Author	Resource/Title	Website/Publisher
World Professional Association for Transgender Health (WPATH)	Standards of care	http://www.wpath.org
Vancouver Coastal Health	Guidelines for transgender care	http://transhealth.vch.ca/resources/careguidelines.html
Vancouver Coastal Health	Clinical protocol guidelines for transgender care	http://transhealth.vch.ca/resources/careguidelines.html
The Endocrine Society	Clinical practice guideline	http://jcem.endojournals.org/cgi/content/full/94/9/3132
Fenway Health	Bibliography and resources	http://www.fenwayhealth.org/site/PageServer?pagename+FCHC_srv_services_trans_bibliography
Tom Waddell Health Center (San Francisco Department of Public Health)	Protocols for hormonal reassignment of gender	http://www.sfdph.org/dph/files/reports/default.asp
University of California at San Francisco (UCSF), Center of Excellence for Transgender Health	Primary Care Protocol	http://transhealth.ucsf.edu/trans?page=protocol-00-00
American Medical Students Association (AMSA)	Transgender health resources (includes guidelines from: WPATH, The Tom Waddell Center, The Endocrine Society, Vancouver Coastal Health, UCSF, Fenway Health)	http://www.amsa.org/AMSA/Homepage/About/Committees/GenderandSexuality?TransHlth.aspx
W.O. Bockting and J.M. Goldberg	Guidelines for transgender care	The Haworth Press, 2006
H.J. Makadon, K.H. Mayer, J. Potter, Hilary Goldhammer	Fenway guide to lesbian, gay, bisexual, and transgender health	American College of Physicians Press, 2007
G.E. Israel and D.E. Tarver II	Transgender care: recommended guidelines, practical information, and personal accounts	Temple University Press, 1998
J. Olson, C. Forbes, and M. Belzer	Management of the transgender adolescent	http://archpedi.jamanetwork.com/article.aspx?articleid=384321

is possible and even likely in some cities that healthcare providers have attended to non-disclosing trans patients in their practice who chose not to return because of unfriendly practices or attitudes and sometimes feeling burdened to educate their providers. Not only does this poor communication further complicate prevalence estimates, it can also perpetuate clinicians' skewed beliefs about the actual size of the trans population, and the likelihood that they will encounter a trans person in their practice. Additionally, since the clinical needs of the trans population vary widely—from basic and preventive screenings and services, to the monitoring of hormone regimens, to surgery-specific follow-up care—it is unlikely that even an uneducated provider will have nothing to offer a trans patient.[12]

The LGBT community has produced a number of excellent documents and guidelines meant to educate and train providers, many of which include specific suggestions about training staff, office logistics (e.g., forms, bathrooms), basic

[12] Indeed, two recent developments regarding U.S. military veterans demonstrate the degree to which trans concerns have entered the "mainstream" of health care: the Department of Veterans Affairs' decision to cover the cost of transition-related counseling and hormones for eligible veterans (Department of Veterans Affairs 2011), and research finding the rate of trans veterans is higher than the general public (Shipherd et al. 2012).

trans-specific medicine (types of surgery, risks of hormone therapy), and acceptable standards of care. We strongly recommend these guidelines, available in Table 16.2, as we have found that materials produced outside of the trans community, even when well-intentioned, sometimes sacrifice sound clinical information for a focus on the exotic and curious aspects of the population. Too often, these texts feature a number of photographs of surgically-altered genitalia but neglects to inform the reader about the medical benefits, risks, and/or follow-up related to that same surgery.

The 2001 documentary *Southern Comfort* chronicles the story of Robert Eads, a trans man who died from ovarian cancer in 1999.[13] Eads identified as a man, but had never pursued genital surgery after he underwent chest reconstruction; in other words, he was a man with the internal reproductive organs of a woman. Eads bore two children with an ex-husband (both were uncomplicated pregnancies and deliveries), but stopped receiving routine gynecological care after he transitioned. Though annual exams may not have prevented his cancer, early detection and treatment may well have reduced the major morbidity and mortality that he subsequently suffered. Due to a combination of some of the factors that we have raised thus far—e.g., a lack of trust in and comfort with providers, a lack of education on the part of his provider(s), and the virtual non-existence of trans-specific screening programs—Eads' cancer remained unmanaged until it had progressed significantly. Even when Eads became aware of his cancer, his search for a provider that was willing and able to manage it was virtually fruitless.[14] *Southern Comfort* chronicles his eventual death over a period of less than a year and documents added barriers to care faced by trans individuals in rural communities.

Though extreme and particularly poignant, Eads' story is far from unique. Rather, it indexes the difficulty that trans patients and bodies pose to the healthcare community: an incongruence between the gender through which they present and live (including to providers) and the "reproductive" anatomy that their bodies may contain. In short, the fact that many trans men have uteri, cervixes, vaginas, and possibly breasts and that many trans women have prostates, testicles, and penises challenges the sex-specific assumptions upon which much healthcare is based. Medical schools have not taught students how to care for a pregnant man, nor how to manage the benign prostatic hypertrophy of a woman; they are even less prepared to offer guidance about how such treatment would be coded and covered by health insurance.

For some trans persons, the preservation of internal/external reproductive organs or secondary sex characteristics is related to a direct challenge to the gender binary; for others, it is related to a lack of access to the healthcare and resources required to secure such physical changes. For a sizeable, and perhaps increasing minority, it is about preserving the genitalia and body parts through which one derives (sexual) pleasure and/or through which one might procreate; and for still others, it is about submitting one's body to as little surgical intervention as possible (Meier et al. 2010a). Regardless of the reasons, the trans population is diverse, which provides challenges to clinicians' assumptions regarding the prevalence of the population, as well as whether and how they could provide care to these individuals.

While at least a minimum amount of training about the trans population for students and clinicians would be ideal (Bradford et al. 2012), this is a group of patients whose bodies disrupt the sex/gender binary in which most of U.S. culture is grounded. Clinicians do not fall outside of these assumptions and, in fact, carry tremendous cultural authority regarding the ways that all of us understand the categories of male and female (Karkazis 2008). For this reason, this chapter is not intended to chastise cis clinicians or readers

[13] Information about Eads sometimes reports his cancer as ovarian and sometimes as cervical; it is unclear which was the primary cancer and if the other was a metastasis but regardless of which, the issues that his story raises (e.g. appropriately targeted screening and prevention efforts) remain the same.

[14] In the film, Eads movingly describes the difficulties that several physicians and their staff had with accommodating him as a patient; he was told, among other things, that other patients (in the waiting room) would be offended or made uncomfortable.

for whom this population may pose a fair to significant amount of cognitive or affective dissonance. Rather, we review some of the barriers in access to healthcare for the trans population in order to provide an opportunity to consider ways in which the health concerns of this population can be more effectively addressed. With that goal in mind, we review five major components to providing care for this population, and then provide a discussion of insurance data and concerns for the trans population.

Health Care

Body Parts

Appropriate screening and clinical management of the trans population requires that clinicians shift their understanding of male and female bodies. In the way that HIV taught many of us to think about risky *behaviors* versus risky *categories*, we need to think similarly about body *parts* in need of screening or intervention rather than sexed bodies themselves. Only in this way can stories like Robert Eads' be avoided. Beginning with patient forms that allow a transgender person to identify themselves outside of a box marked "male" or "female," clinicians can learn to ask patients (particularly those who feel comfortable enough to come out as trans) about which types of body modifications (if any) they have pursued thus far, in addition to inquiring about which might be planned or desired. Open-ended questions that allow the patient to describe the extent of their bodily transitioning will provide the clinician with the most accurate information regarding the optimum medical management of the patient. When this is not done, men who need mammograms or a Gardasil vaccine and women who need prostate-specific antigen (PSA) bloodtests will be ignored and preventable disease conditions will likely go undetected.

Whether and to what extent such procedures will be covered by insurance or federal or state-sponsored healthcare subsidies is an entirely different set of questions. Because federal healthcare reform was passed as this chapter was being written, it is impossible to delineate the effects that new regulations will have on the trans population. However, we can say that clinicians who are increasingly willing to provide these services in an unbiased manner will likely contribute to greater overall access and acceptance. Insurers often take their cues from clinicians and will likely respond to a market that demands and requests services. With President Obama's appointment of a trans woman to work in the federal Department of Commerce, many in the trans community are hopeful that insurance regulations will be written with a sensitivity to some of these issues.

Hormones

Regardless of surgical alteration, many trans people use some kind of exogenous hormones as part of their gender affirmation treatment, each of which entails particular risks and health consequences. Just as we stressed in the last section, clinicians should evaluate the hormones in combination with the particular body/body parts of the patient: since exogenous estrogen has been correlated with both uterine and breast cancers *as well as* with strokes and other thrombotic events, it is important that clinicians sort through the potential risks that are specific to each patient's hormonal and clinical profile. Notably our present discussion is limited to the use of hormones in adults, and will not include the use of hormone blockers in trans teens hoping to offset the physical and physiological changes associated with puberty and with the advantage of being "reversible" if one should wish to discontinue if discomfort ensued. Though data collected thus far have shown the practice to be safe and effective in alleviating gender dysphoria, it remains a highly controversial topic.[15]

Because peri-and post-menopausal women have been using exogenous estrogen as a part of their Hormone Replacement Therapy (HRT) for some time, many of its risks and benefits have been

[15] Interested readers are encouraged to consult: Cohen-Kettenis and van Goozen (1998), Delemarre-van de Waal and Cohen-Kettenis (2006), Olson et al. (2011) and Rosin (2008) for further discussion of the hormonal suppression treatment of trans children and adolescents.

well researched and delineated; we can therefore draw some conclusions about the use of estrogen therapy by trans women. Like (peri)menopausal women, trans women using exogenous estrogen will carry an increased risk for particular problems and side effects, all of which should be thoroughly discussed with the prescribing or managing provider. And also like these women, trans women must weigh these risks against the benefits that, though distinct, make a material and daily difference in their bodily experience.

In general, estrogen use is associated with the following side effects: a redistribution of fat to the hips and breasts; an (eventually) lessened production of body hair, and slowed loss of scalp hair; and a likely decrease in spontaneous penile erections. Estrogens have also been shown to increase bone density. In addition to these (mostly) desired effects, hormones can lead to other effects that can be problematic if not managed properly. Estrogens can increase the risk of uterine and breast cancers, and can lead to an increased incidence of thrombosis, strokes, and other cardiovascular events (Asscheman et al. 1989; Levy et al. 2003; Moore et al. 2003). However, the long-term effects of exogenous estrogen in birth assigned males have yet to be delineated (Gooren 2005; Gooren et al. 2007; Moore et al. 2003).

For trans men, androgens can carry the following side effects: a redistribution of body hair (to the face, chest and limbs); a deepening of the voice; an emptying of fat from the breasts[16] and a thickening of the waist; and an increase in the size of the clitoris. There is also some data to suggest that spatial sensibilities will be improved (van Goozen et al. 1995), and both men and women have been shown to have increased libido with the use of exogenous testosterone. Though regular use will likely lead to a cessation of menstruation in two to six months after initiation (WPATH, 2011; Olson et al. 2011), the overall effects of testosterone on the female reproductive organs are less clear. Some researchers assert that there is little to no effect; others argue that because testosterone is aromatized to estrogen in the body, there is a theoretical increased risk of breast and uterine cancers (Baba et al. 2006; Mueller et al. 2008). In a recent study of 134 FTM's, Rachlin and colleagues found that a significant number of trans men undergo hysterectomy and/or oophorectomy due to concerns about the effects of testosterone on female reproductive organs, though their review of the data found no evidence that these concerns were substantiated. What they did find, however, was that though trans men are advised to decrease their levels of exogenous testosterone after these surgeries, a reasonable majority do not (Rachlin et al. 2010). A recent article in the *International Journal of Transgenderism* speculates about the still-unknown impacts of testosterone on the quality and/or production of eggs in trans men (van Trotsenburg 2010). Though individuals like Thomas Beatie have demonstrated that trans men can indeed conceive and bear children using their still-intact "female" reproductive organs, it is too early to determine whether long-term use of testosterone will complicate or mitigate this possibility for the larger population of trans men. There is also speculation about the psychological side effects associated with the use of both exogenous testosterone and estrogens (Gorton et al. 2005); it is difficult, however, to disentangle psychological side effects of hormonal therapy from the psychological issues that often accompany transitions at all stages.

Finally, many trans people take hormones without a prescription (Gooren 2005; Moore et al. 2003), usually because it is either more affordable or is more geographically accessible. Clinicians must take care not to pass judgment on these individuals but rather inquire about the patient's reasoning and seek to establish a system of monitoring if the patient cannot participate in a more clinically supervised regimen. Buying hormones over the internet is common, but this situation is not unique to trans patients—the purchase of less expensive pharmaceuticals for depression, hypertension, contraception, and a

[16] For the vast majority of trans men, this will not satisfy their desire (if they have it) to remove their breasts. Testosterone cannot eradicate breast tissue; only a mastectomy can do that. Some trans men may lose enough mass with testosterone that binding can be enough for them, however.

host of other conditions has become quite commonplace in the first decade of the twenty-first century. Clinicians should explain the risks of side effects and inquire as to whether s/he wishes to be routinely monitored and have their risks clinically managed (e.g., with appropriate screening and early detection methods).

Research on hormone use is likely to yield continued surprises, including that the use of hormones may enable smoother transitions for some trans people. For example, for the subpopulation of trans individuals who choose to go "stealth," (i.e., not disclose their transgender status), many in the trans population believe that the constant need to "hide" their identity can provoke significant amounts of anxiety. This has recently been challenged, however, by preliminary data from Meier and Hughes (2010), who found that individuals who consider themselves stealth reported higher levels of quality of life than their more open counterparts, a finding that was mediated by testosterone use. This may indicate that testosterone use contributes to higher quality of life, regardless of stealth status. Indeed, this research suggests that, on average, these people were extremely well-adjusted.

As with other clinical regimens, the *Endocrine Society* has published standards that clinicians can use for guidance (Hembree et al. 2009; Bockting and Goldberg 2006; Feldman and Goldberg 2006; Gorton et al. 2005; Leli and Drescher 2004; Lombardi 2001; Nesteby, n.d.).

Gender Identity Does Not Equal Sexual Orientation

It is important for clinicians to understand this fact (Diamond 2002). As we reviewed in our first section, there is little to no consistent data regarding the sexual orientation of this population; indeed, data collected by the transgender community is beginning to demonstrate that transgender individuals are as sexually diverse as any other demographic "group" (Meier et al. 2013). As with any other patient population or individual, clinicians must continually work to undo the assumptions that they have about what kinds of sexual behavior and partners these patients are likely to have.

Gender Affirmation Treatment (GAT)

There are many trans individuals who will pursue what might be thought of as a "traditional" course of treatment, i.e. one through which they desire to transition from one clearly defined sex/gender to *the* other (as opposed to *an*other). For trans women, this may include: breast augmentation, penectomy and orchiectomy, vaginoplasty with or without labiaplasty, and daily/maintenance use of exogenous estrogen. Supplemental therapies may include facial feminization procedures, chondrolaryngoplasty (tracheal shaving), voice retraining, and hair removal procedures (electrolysis, waxing). For some trans men, a "complete" transition may include mastectomy (possibly with nipple repositioning), hysterectomy and salpingo-oophorectomy, androgen/testosterone supplemental maintenance, phalloplasty or metoidioplasty with urethral extension, vaginectomy, and scrotoplasty.

It is important that physicians are aware of which aspects of gender affirmation treatment (GAT) are and are not reversible; surgical alteration is obviously irreversible, although depending on the patient's resources, additional procedures can be performed to restore or reconfigure bodily changes. Hormonal effects vary—most of the effects of both estrogens and androgens are eventually reversible, although the effects of testosterone are less reversible than estrogen. For example, changes that testosterone induces to the skeletal structure including the jaw and pelvis, the voice, male-pattern baldness, additional body and facial hair, and clitoral growth are not thought to be reversible (Dahl et al. 2006; Gorton et al. 2005; Meyer et al. 2001). In the event that patients were concerned about reversibility, it would be important for a primary care clinician to carefully assess their reasons why, and to refer them to a trans-specialist psychotherapist whether these concerns are raised before or after treatment. It is possible that a patient might seek out GAT for reasons other than a "true" transgender identity, e.g., a belief that if one has a homoerotic sensibility, then one must need to make one's sex/gender somehow congruent. It is also possible that other forms of mental illness/

pathology (e.g. schizophrenia) might manifest as a desire to change sex or gender (Cohen-Kettenis and Gooren 1999; Mizock and Fleming 2011) for this reason, major concerns about reversibility should be carefully assessed and properly referred in order to provide the best care for the individual in question.[17]

In summary, treating a transgender patient requires a reorientation in clinical and personal assumptions about sex and gender; it is vital that clinicians unseat as many of their own as they can in order to best care for this population. Questions such as "What is your gender identity? Gender expression?" and "Have you had any kinds of body modification? If yes, can you describe them to me and do you wish to have any in the future?" cannot only demonstrate a fundamental respect for the transgender patient, but can also assist the clinician in providing the most comprehensive care for the unique healthcare needs of each transgender patient. For a trans man featured in Frameline's short film "TRANSforming Healthcare" by Ethan Suniewick, the distressing fact that his doctor literally did not know what to do with his body left him feeling profoundly medically neglected (Suniewick 2007). After being told "Well, if you were a girl, I'd have you lay down like this, but …," he left the office and told the filmmakers, "So I was pissed because I didn't receive health care." In order for this trans man to not become another Robert Eads, clinicians should consider incorporating new cognitive, affective and psychomotor skills (Ross 1984) that adequately address the needs of the transgender population.

Insurance

In general, GAT is not covered by insurance. Costs for typical procedures and transition aids can be quite high, as reflected by the estimated costs in 2010 that are listed in Table 16.3. However, as we have stated, many of the healthcare needs of the trans population have nothing to do with "reproductive" or sex-specific body parts or systems. In other words, a trans man or woman who is able and willing to work with a knowledgeable therapist and to be given a diagnosis of GID or Gender Dysphoria may ultimately be able to secure insurance coverage for their GAT. A trans person unable or unwilling to be diagnosed as such, or who is less invested in "transitioning" from one side of a binary to another, will still have unique health care needs outside of genital or hormonal transitioning. It is likely that this care will remain uncovered, even as health care reform is instituted in the U.S.

Table 16.3 Cost of transitioning aids (in U.S. dollars)

	Price range
Surgical	
Breast augmentation	$3,000–$6,000
Breast reduction/chest reconstruction	$6,000–$10,000
MTF genital reconstruction	$12,000–$30,000
FTM genital reconstruction	$5,000–$75,000
Hysterectomy	$10,000–$20,000
Facial feminization	$5,000–$100,000
Non-surgical	
Breast forms	$100–$2,000
Chest binders	$30–$75
Electrolysis (facial hair removal)	$800–$5,000
Packers	$20–$100
Stand to pee devices	$35–100
Penile prostheses	$700–$2,000
Vocal coaching	$20–$1,500

Given the difficulties that trans people have in work situations and in securing the legal right to marry, it is likely that a majority of the population will not have adequate healthcare coverage. Currently, it is estimated that 32–87% of trans people are insured, (Table 16.4; Transgender Law Center 2008; Xavier et al. 2005, 2007). However, FTMs may be more likely to be insured than MTFs, with one study of trans people of color finding that 15% of MTFs and 58% of FTMs have insurance (Meier et al. 2010a; Xavier et al. 2005). Having health care insurance does not guarantee access to trans related health care, and 10% of the time trans people with insurance report

[17] Interested providers can access primary care protocols and provider trainings from: www.transhealth.ucsf.edu

Table 16.4 Statistics from insurance-related studies of trans people

Meier et al. 2010a (n = 1067; all FTMs)	
Have insurance	74%
Of the uninsured: Do not have insurance due to associated costs	31.6%
Of the insured: Insurance covers trans related health care	20.5%
Transgender Law Center 2008 (n = 646; 375 MTFs, 271 FTMs)	
Have insurance	86.5%
Were denied surgery	33%
Were denied hormones	27%
Were denied counseling and mental health services	21%
Were denied gender-specific care (such as pap smears for trans men and prostate exams for trans women)	15%
Were denied primary health care	10%
Delayed healthcare due to finances	42%
Health condition worsened because they postponed care	26%
Xavier et al. 2007 (n = 350; 229 MTFs, 121 FTMs)	
Have insurance	72%
Have a regular doctor	62%
Educated their doctor about their healthcare needs	46%
Experienced discrimination from healthcare provider	24%
Non-disclosing with regular doctor	29%
Xavier et al. 2005 (n = 248; 188 MTFs, 60 FTMs)	
Have insurance	32%
Have access to annual physical exams	54%
Have access to gynecological care	10%
Experienced caregiver insensitivity	33%

that they have been denied primary health care. Twenty-one percent of FTMs in one sample reported that their insurance covered trans related health care (Meier et al. 2010a). In another sample of trans people, 33% of those surveyed reported having been denied coverage for surgery, 27% for hormones, and 21% for counseling and mental health services (Transgender Law Center 2008).

These data regarding coverage could result in trans individuals using what little money is available for healthcare on surgery and/or hormones, or other costs associated with maintaining their congruent gender expression. Without insurance, hormones may be acquired through non-medical channels or sources, and there is a reasonable risk of using doses higher than what are recommended by regulating institutional bodies. It is also true that many trans individuals pursue GAT, especially surgical procedures, in countries where the cost is much lower (e.g., Thailand, Mexico). Indeed, there is anecdotal evidence suggesting that some trans women acquire industrial-grade silicone in order to increase the size of their breasts at a lower cost. Available in liquid form, and used by some transgender sex workers in parts of Brazil, silicone can be directly injected into the chest, buttocks and thighs by the individual and/or an accommodating friend. This cannot only pose problems for the U.S.-based physicians who later manage these patients, but also pose significant legal and re-entry problems for patients whose gender identity and/or expression has changed while they have been out of the country. Similarly, a transgender person wishing to undergo sex-specific GAT procedures, such as a hysterectomy or mastectomy, may find that the surgeries are uninsured if they legally changed their gender beforehand.

These practices could not only put these individuals at risk, but could also further alienate them from clinicians who disapprove of non-compliant patients. Twenty-four to thirty-three percent of trans people report experiencing discrimination or insensitivity from health care providers (Xavier et al. 2005, 2007). Though physicians have the right—and at times responsibility—to withhold services or treatment from patients who do not follow their treatment guidelines, it is vital that clinicians cultivate an appropriate sensitivity to the plight of trans patients—a lack of economic access and the desire to avoid discriminatory attitudes are just two of the reasons that trans patients may not readily "comply" with particular clinical recommendations. Ironically, anecdotal evidence has demonstrated that trans patients can be quite compliant when cared for by educated providers. Not only is it in their clinical interests (e.g. better managed side-effects and/or surgical outcomes), but "good behavior" is also more likely to secure the letters and authorizations that many trans people need in order to obtain legal and institutional-level changes.

Population Health: Mental Health

Many mental health providers are hesitant to work with transgender clients because they do not feel informed on the population's specific needs (Meier and St. Amand 2010). Without a better idea of the demographics of this population, these providers may feel justified in never working with trans people with the thinking that "there aren't very many of them." With more demographic data, as well as scientific studies on the efficacy of treatment and updated treatment guidelines, providers can feel more fully informed and competent and less inhibited to work with members of this population. This section, therefore, explores current data regarding the prevalence of mental health concerns within the trans population. Further, we detail some of the precautions that must be taken when using these data to estimate prevalence, as well as for developing mental health interventions.

The history of mental health research on the trans population is rife with two sets of claims: that trans people are delusional or have gross forms of psychopathology, and that trans people are actually quite normal and are often of above average intelligence (Huxley et al. 1981b; Gomez-Gil et al. 2008). Many of these claims are ideologically charged, making the task of "proving" their relative truth challenging at times. But it is safe to say, based on a preponderance of psychological research, that trans people demonstrate consistently high levels of psychological/mental health despite high incidences of risk for negative outcomes (Meier et al. 2011; Rachlin 1999; Ross and Need 1989).

Certain groups of trans people have been studied more than others, as most past research has tended to focus on trans women (MTFs) rather than trans men (FTMs). At this time, there are extremely limited data on trans people who identify as genderqueer. This disparity may be due to MTFs requesting medical services such as genital surgery more often than FTMs or genderqueer people (refer to the Prevalence section) or it may reflect that more FTMs are non-disclosing than MTFs (Rachlin 1999).

Conducting research among the trans population is difficult due to the relatively small size of the population, but also because many trans people are wary of researchers. Aware of the fact that they have historically been presented in a negative, pathologized light, many are hesitant to participate in studies. This is especially true for trans people of color, who are rarely represented in large studies (Erich et al. 2010). Participants in a workshop conducted at a gender conference for trans people of color voiced that they would prefer not to be "guinea pigs" for research studies. However, once they were informed about how research can change both legal and medical policies and the "you don't exist unless you are researched" phenomenon, the participants spoke of how they would be more willing to participate in studies, especially if the investigator is a person of color (Erich et al. 2010).

Higher Incidence of Psychological Problems

Do trans people really suffer from a higher incidence of psychological problems? The answer to this depends largely on the research that one is consulting. Older formal studies measuring hospital patients and sex workers, for example, provide vastly different results from studies conducted over the Internet and more recent studies of patients at gender clinics, regardless of which population is being described (APA 2009; Hoshiai et al. 2010; Meier et al. 2011). Critical readers should therefore look carefully at who is being measured by the research (how they define the population), who is doing the measuring, the temporal location of the population ("stage of transition", "puberty"), and the methodology, all of which provide important interpretive context.

Increased rates of depression, anxiety, substance use and abuse, rape, intimate partner violence, suicidality, and self-injurious behavior have been reported to occur in the trans population as compared to the cis population (Clements et al. 1999; Cole et al. 1997; Courvant and Cook-Daniels 1998; Dickey 2010; Grossman

Table 16.5 Rates of suicidal ideation/attempts and problematic substance use

Assessment	Source	Participants	Rate	Reference
Rates of suicidal ideation/attempts				
Lifetime attempt(s)	Community and clinic	392 MTF; 123 FTM	32%	Clements-Nolle et al. (2006)
Lifetime attempt(s)	Internet	448 FTM	44%	Meier and Pardo (2010)
Lifetime attempt(s)	Community	113 MTF; 69 FTM	30.1%	Kenagy (2005)
Lifetime attempt(s)	Gender clinic	318 MTF; 117 FTM	15%	Cole et al. (1997)
Attempt(s) and ideation	Community; trans people of color	188 MTF; 60 FTM	38%; 16%	Xavier et al. (2005)
Attempt(s) and ideation	LGBT youth services; age 15–21	31 MTF; 24 FTM	26%; 45%	Grossman and D'Augelli (2007)
Attempt or ideation (past year)	Community	141 MTF; 34 FTM	52%	Bockting et al. (2005)
Rates of problematic substance use				
Alcohol and Marijuana use	Community agency; youth of color age 16–25	51 MTF	65%; 71%	Garofalo et al. (2006)
Heavy alcohol use	Community, Latino GB and T persons	549 GB; 94 MTF	26%	Ramirez-Valles et al. (2008)
Alcohol and drug problems	Internet	448 FTM	23%; 19%	Meier (2010)
Substance abuse problems	Gender clinic	318 MTF; 117 FTM	28%	Cole et al. (1997)
Self reported substance abuse	Community; trans people of color	188 MTF; 60 FTM	48%	Xavier et al. (2005)
Alcohol or drug treatment	Community and clinic	392 MTF; 123 FTM	28%	Clements-Nolle et al. (2006)

and D'Augelli 2007; Hendricks and Testa 2012; Kenagy 2005). Some researchers have suggested that risk factors that increase these negative outcomes may consist of being denied access to care (Meier et al. 2011), stigma (Bockting et al. 1998), as well as the loss of social support from loved ones (Meier et al. 2010b).

It is important to complicate these findings, however, as we should not assume that these rates derive straightforwardly from a trans identity. The APA Task Force on Gender Identity and Gender Variance states, "Studies on the mental health of transgender individuals are limited by the use of convenience samples and may not be generalizable to the overall transgender population" (APA 2009: 42). Further, the results of these studies vary widely, yet there is some evidence to suggest that trans people who have experienced violence or victimization are at greater risk for suicide attempts (Goldblum et al. 2012; Testa et al. 2012). For example, research has suggested that anywhere from 16 to 52% of trans individuals have attempted suicide and that rates of "recent heavy alcohol use" within both MTF and FTM populations have ranged from 8 to 31%; illegal drug use, when measured, has ranged from 3 to 71%, depending on the drug (Bockting et al. 2005; Clements-Nolle et al. 2006; Garofalo et al. 2006; Grossman and D'Augelli 2007; Hendricks and Testa 2012; Kenagy 2005; Ramirez-Valles et al. 2008; Xavier et al. 2005). See Table 16.5 for an overview of the research studies on rates of suicide and problematic substance use.

While we recognize the importance of collecting these data in order to better understand the association between a trans identity and high risk behaviors, we also acknowledge that prevalence rates can and do determine interventions and analyses. Though compelling in its own right, addressing a suicide attempt rate of 16% may require a

distinct set of tools from that required to address a 52% rate. As a result, it is important to take a critical look at the methods of psychological studies on trans people, focusing on the sample and data collection process (i.e., age, genders, recruitment method, hormone/surgery status, race/ethnicity, geographical location, etc.) in order to have a context for how to interpret the data and the generalizability of the results. Scholars should critically evaluate findings so as to not overlook important mediating and moderating variables. For example, an Internet study on mostly white and highly educated trans men found normal to mild levels of depression and anxiety, which varied based on whether the trans men were on testosterone or not (Meier et al. 2011). This could suggest that demographic factors, including race and education, moderate the effects of a trans identity on mental health outcomes.

Psychotherapy Concerns

Trans people also seek mental health services for reasons unrelated to their gender identity and expression or their desire for letters of support. They may desire therapy to address depression, anxiety, grief over the death of a loved one, sexual assault, or any number of concerns. They may also seek couple's therapy or career counseling. Regardless of why trans people come to therapy, they always have a choice of whether or not they are going to disclose a trans history. More accurate demographic information will aid researchers in obtaining grant funding to determine which pre-existing evidence-based interventions are effective for trans clients and to develop novel evidence-based interventions that are inclusive of trans clients and their partners and families.

As we stated earlier, it is possible that a clinician who does not believe that they have seen a trans client actually has (see discussion of stealth status in the Prevalence section). Clinicians working with someone they perceive to be trans need to determine if it is clinically relevant to ask questions concerning the client's body or desire for body modification. Nonetheless, it is important for providers to consider their reasons for asking the question. If the answer is curiosity, it is likely that it is not clinically relevant and asking prematurely could damage rapport with the patient (though making assumptions about someone's trans status can be equally damaging). For example, if a therapist is working with a trans woman who has neither had nor desires genital surgery and that therapist makes the assumption that all trans people desire genital surgery, the therapist may inadvertently behave in a manner that pressures the client to pursue surgery or to end therapy as she may not feel understood. This mistake could be avoided more often if clinicians had a better idea of the prevalence and costs of GAT in FTMs and MTFs (see Tables 16.1 and 16.4).

Due to lack of education, training, and exposure to trans people, many therapists unknowingly assume that there is a single or "correct" trans history and identity where trans patients report feeling trapped in the wrong body since childhood and that they are 100% the "other" gender. While that might be a common narrative, there is no single or correct trans history or identity, as the population is more diverse than most imagine. There are some people whose gender identity is fluid and changes over time, others report feeling "trapped in the wrong body" since early childhood, still others do not discover their gender identity until late in life. Historic accounts of the treatment of trans people who did not report a "classic" history (i.e., genderqueer persons or trans people reporting a post-transition gay orientation), demonstrate that many of these individuals were not given letters for treatment and thus denied many of the services they sought (Lev 2005). For these reasons, it is important to collect additional data so as to generate information regarding the diversity of transition experiences (IOM 2011).

Organizations that promote the idea of "changing" or "repairing" a person's sexual orientation and/or transgender identity are still in existence; they are most typically affiliated with religious organizations. Despite a lack of solid empirical evidence demonstrating the efficacy of these

treatments, many of these groups promote their success on websites and through self-published materials. Indeed, it is easy to encounter one of these websites when casually searching online for transgender information. It is important that those invested in the transgender population keep abreast of these trends and "treatments" as at least one scientist has demonstrated that they are associated with notable negative outcomes (Drescher 2002). In fact, the APA has issued a press release stating that these "treatments" do not have evidence supporting their effectiveness and that psychologists should not tell clients that they can change their sexual orientation (Glassgold et al. 2009).

In 2009, the American Counseling Association published important new guidelines for professionals who counsel and/or conduct research with trans people (ALGBTIC 2009). The World Professional Association for Transgender Health also released suggestions for therapy with trans people (WPATH 2011). Such guidelines hopefully can address a vital issue affecting the competent mental health care of this population, which is the lack of training and the lack of incorporation of the LGBT literature into mainstream psychology (Goldfried 2001). Numerous trainings exist to educate straight cisgender people; however, many of these focus so heavily on LGB issues that trans issues seem like an afterthought. Some trainings neglect to mention the trans population at all or when they do, emphasize that "those people" are inherently different than the "regular" LGB population. One of the authors is part of a network that exists to address this problem. The 44th Division of the American Psychological Association recently created a list of professionals who are available for comprehensive LGBT trainings.[18] Also, many valuable resources have already been created for educating clinicians on culturally sensitive trans affirming care (APA 2009; Lev 2004; Maguen et al. 2005; Raj 2002). Hopefully these resources, and future resources which may be better informed by demographers, can help mental health practitioners to provide competent care to this population.

[18] Interested readers can contact Division 44 of the American Psychological Association for an updated list of resources and contacts.

Family Demographics

Relationships

Historically, researchers have been openly shocked that cisgender people would want to form or continue meaningful romantic and sexual relationships with trans people (Brown 2009; Fleming et al. 1985, 1984; Huxley et al. 1981a). In fact, historical anecdotal reports from trans people who were treated at gender clinics claim that married trans people were encouraged to divorce before starting their transition (Samons 2009). Empirical data show that about half of the partners of trans men stay with their partner through transition, and, of the half that do not stay together, half of them (25% of the overall sample) end the relationship due to their partner's transition (Meier et al. 2010c).

More recently, many qualitative interviews have focused on partners who stayed with their transgender partner through transition (Brown 2009; Ehrbar 2010; Kraemer et al. 2010). Partners of trans people provide important social support to their trans partner (APA 2009; Ehrbar 2010). However, partners also benefit from having their own social support and accessing resources related to transition (Ehrbar 2010; Meier et al. 2010c). Partners who stayed with their trans partner through transition attributed the success of their relationship to open communication, education on transgenderism and the transition process through accessing resources, community support, and keeping their focus on the reasons they fell in love with their partner in the beginning of their relationship (Meier et al. 2010c). Kraemer and colleagues (2010) encourage professionals who work with the trans community to cite many positive and healthy examples of trans relationships in which a cis partner accepts and affirms their trans partner as they identify.

Trans people can have relationships with all types of partners: cis males and females, as well as with other transgender people. In a study of over 500 FTMs, about half of the participants reported being in relationships at the time of the survey, with 42 participants reporting being legally married (Meier et al. 2010c). Over one-third of the trans women in an Irish research study reported being married currently or previously (De Gascun et al. 2006). In some cases, depending on the legal precedence where the partners reside, these relationships may be legally recognized in marriage or domestic partnerships. Some partners conceptualize their relationship as LGBQ and some as straight/heterosexual based on the gender identities of the partners, as opposed to their birth-assigned sexes. As such, demographers should be mindful of the way they attempt to quantify these relationships.

Family

One in five to one in three trans people are parents, with trans women more likely to be parents than trans men (De Gascun et al. 2006; Freeman et al. 2002; Meier and Hughes 2010). Depending on the state or country, trans people may be allowed to marry and/or adopt children within the context of a heterosexual relationship or marriage; when some do not identify as heterosexual, trans individuals encounter obstacles to both of these practices that are similar (though perhaps heightened) to those encountered by gay men and lesbians. These include: discrimination, inadequate legal rights (e.g., parental decision-making, legal privileges on behalf of children and partners), and accusations of gender fraud. Even with these obstacles, having a trans parent has not been found to be harmful for children (Green 1978).

As with Thomas Beatie, people that delay or opt out of genital surgery may father or bear children within the context of a trans body and relationship. It should also be noted that some trans people bear and raise children before they transition, in which case many of the issues faced by these individuals are more personal than legal. Children and other family members do not always understand nor accept the trans person's desire to express their gender identity, and sometimes sever ties as a result. Overall there is a paucity of published research "on the family issues of adult transgender people, in spite of the importance of social support from families for satisfactory mental health" (p. 3; APA 2009). Though preliminary data (Meier and Hughes 2010) suggests that trans parents experience fewer symptoms of depression, anxiety, and stress than trans non-parents, these measures of well-being seem to be correlated with age, hormone usage, and/or time since transition, indicating that older trans people experience fewer psychological symptoms (Meier and Pardo 2010). Many families eventually become accustomed to having a trans parent (or aunt, uncle, etc.) as much of the initial disruption evens out over time; indeed, family members sometimes become politically active as a result of witnessing the discrimination and obstacles faced by their loved ones.

Many other trans individuals are not as fortunate, however, and lose the support of their families of origin and/or that of their partner/spouse and children. Though not unique to this population, such a loss can leave trans people without a fundamental component of a social "safety net." Without legal access to a family of choice, it can be crucial to have one's family of origin in place for financial and emotional stability, particularly when one is routinely subjected to discriminatory tactics and attitudes. A potential negative ramification of being diagnosed with a "mental disorder" is that an ex-spouse may use that diagnosis against a trans person in a custody case as evidence "proving" the trans parent to be an unfit parent, as they "are mentally ill," (Ehrbar 2010). Scenarios like this will likely be lessened when research findings demonstrating the "normal" and competent parenting and relationships of trans people become more widely available. Loss of family support has been found to have deleterious effects on the mental and physical health of trans people, as family support can act as a buffer to stigma and discrimination (APA 2009). Data show that loss of family support is related to lower general physical health and functioning

quality of life ratings in FTMs, a result similar to the findings from the Family Acceptance project's work with LGB youth (Meier et al. 2010b; Ryan et al. 2008). The converse also holds for both sets of data: the higher the social support ratings of families that do accept their children, the higher the quality of life results for those children. Findings from a recent study of Canadian trans youth demonstrate that trans youth with strong parental support report higher satisfaction with life, higher self-esteem, less depression, fewer suicide attempts, and adequate housing compared to trans youth without strong parental support (Travers et al. 2012). Organizations such as PFLAG (Parents and Friends of Lesbians and Gays), which for over a decade has incorporated a transgender arm (T-Net), COLAGE, a national support and advocacy group for children with (at least) one gay, lesbian and/or trans parent, TYFA (Trans Youth Family Allies) and Gender Spectrum (see Brill and Pepper 2008), both groups for families of trans youth, are working to educate the greater population about these issues.

Labor Demographics

The experiences of trans people in the workplace have begun to reveal that all experiences of trans people are not equal, and that broader social phenomena such as masculine privilege can override the discrimination that a trans person might experience on the job. In a sociological, interview-based study with trans men, Schilt (2006) found that white, tall trans men who transition on the job are more likely to keep their employment and to get promoted than are short, trans men of color and/or those trans men who are not on testosterone. Furthermore, cis men appear to recognize trans men who make a gender transition on the job as simply *men*, whereas cis women are more likely to recognize these individuals as *trans* men (or someone who once was a woman) (Schilt and Westbrook 2009). Schilt (2010) records a workplace experience of a gay trans man who works as a kindergarten teacher in Texas. This trans man does not disclose his trans history to most of his colleagues. During teacher meetings, he noticed being treated differently than the other (mostly female) teachers. Specifically, he noticed that because he is a socially recognized male, other teachers often stop talking when he speaks and that when he presents an idea, even if it was first raised by a female colleague, he is listened to and taken more seriously.

Survey research has thus far borne out such findings. Schilt and Wiswall (2008) tested the concept of "gender/appearance-neutral" performance reviews and pay structures. They hypothesized that if this theory holds true, people who transition should be paid the same amount for the same work both before and after they transition. What they found was that trans women, on average, lose $12/h after they transition and trans women also make more than do the average male and female workers before they transition. Trans men, on the other hand, did not lose money related to their transitions; indeed, some even made a small amount more afterwards.

Because of these demonstrable and gendered disparities, Schilt and Wiswall (2008) encourage scholars to use caution when speaking about the trans population and to not generalize about the "transgender experience" at work. Moreover, most research focuses on trans people at the time of their gender transition; the workplace experiences of people who transitioned in the more distant past are still relatively unknown.

Gender Alterity in a Broader Context

We conclude with both a restatement and an elaboration of our opening position: that this chapter is written from a (primarily) U.S.-based set of facts, beliefs and organizational frameworks about a trans reality. It is important to restate this because both authors believe strongly that the aspects of sex and gender that are socially constituted and contoured cannot be disentangled from those that may not be, i.e., that may originate from a more "natural" source. This means that we encourage the reader to understand this demographic profile as representing an experience of trans that is both historically and geographically

specific, one possible way that gender alterity can be lived and expressed. Anthropologists in particular use both historical and cross-cultural evidence to suggest that other societies and cultural groups often hold an affirmative place for people and bodies who are not neatly categorized by either male or female. In order to underscore this final point, we will outline a few of the ways that sex and gender expression are and have been lived across other parts of the world and at other points in time.

As we have mentioned, the terms *transgender* and *transsexual* already connote a binarized understanding of gender; the fact that one can "cross" from one to the other is implied within the words themselves. For the *travesti* in Brazil, however, there is no such easy crossing. Travesti are what many in the U.S. would call MTF: birth-assigned men who dress, act, and self-identify as feminine (including calling themselves "girls"), and who define their male partners in heteronormative terms (Kulick 1998; see also Prieur 1998 for similar findings in Mexico). A hallmark of travesti identity is the injection of industrial-grade silicone directly into the hips, buttocks and breasts, a set of procedures that typically fortifies the incomes many of them make doing sex work. Travesti are subjected to discrimination and harassment, frequently from the police, and often live at or below the poverty line. Given these parameters, it is tempting for even gender scholars to label these Brazilian women *transsexual* but the travesti interviewed by Kulick spoke clearly and openly about how that concept does not represent their experience. Indeed, the idea that a man could "become" a woman through surgery and/or hormonal therapy is quite unthinkable, and many of the travesti in Kulick's ethnographic study report a bodily investment in their penis that would preclude its excision or even subordination. Moreover, in both Kulick's and Prieur's studies, the category of transgender articulated with particular forms of masculine or "bisexual" expression, in that many of the steady sexual partners of the transgender sex workers were men who considered themselves to be heterosexual.

Indian *hijras,* on the other hand, have no such investment in their male genitalia. Rather, the *nirvan* surgery that many of these birth-assigned males undergo consists of the complete excision of both penis and testicles. Although the *hijra* might also be loosely translated in MTF terms—they dress as women, take female names, and participate in female-gendered activities—their gender alterity is rooted in a very specific set of spiritual and religious practices. Often referred to as India's "third sex," *hijras* sacrifice their genitalia to a goddess in exchange for the power to confer fertility and blessings on (heterosexual) newlyweds and newborn children (Nanda 1990; Reddy 2005). An important similarity that the *hijra* have to *travesti* is that, contrary to what the trans community is articulating in the U.S., they understand their gender alterity at least partially through their sexual practices. Both groups have primarily male sexual partners; their understanding of themselves as not exclusively male does not arise from their identifying as "gay," however. Rather, both *travesti* and *hijra* conflate the (anally) receptive position in sexual intercourse with femininity and female comportment, an understanding that endows their male (and penetrative) partners with a clearly defined masculinity.

In a widely cited study of female "homoerotic" identities in ancient India, Penrose (2001) claims that though a variety of alternate genders existed in what is now South Asia, the majority have disappeared through the effects of Muslim and Christian invasions, colonialism, and a decline in Buddhist practice. These historical developments are important to underscore as they illuminate the sometimes precarious relationships between sex/gender systems and wider cultural and political institutions and practices. Penrose discusses female warriors, for example, who served as bodyguards to precolonial South Asian royalty, and the *yellamma* who served as porters of sacred objects. Some, though not all, of these identities were organized around the birth-assigned females' disinterest or unwillingness to engage in sexual relationships with men; such a predilection could open up "male" opportunities for these women, allowing them to maintain a social role outside of marriage. It is unclear whether and to what degree any of these individuals experienced

a feeling of gender incongruence the way that many contemporary transgender individuals do. What is clear, however, is that sex and gender have most likely always been experienced—by both individuals and groups—outside the domain of a (heteronormative) male/female binary. The elaboration of this simple fact with cross-cultural and historical research can have an extremely normalizing therapeutic effect on individuals struggling to come to terms with their gender variance.

Numerous other examples exist: Albanian sworn virgins, Thai *maa khii,* Hawaiian *mahu,* Native North American (Navaho) *two-spirit,* Jamaican *tombois,* Sobar *Xanith*, Tiwi Islands *sistagirls*, and South Asian *jogamma, jogappa* and *sadhin.* Much of the archival and ethnographic research conducted with and about these groups is being done by queer and trans scholars, leading to what some view as an ever-expanding acronym to adequately capture the contemporary "smear" of gender and sex expression (e.g. the initials "I" and/or "TS" are sometimes appended to LGBT in order to recognize intersex and "two spirit". Though challenging for those attempting to standardize and quantify this population, the seemingly boundless nature of this terminology indexes one of the most salient elements of a trans identity: its culturally constructed nature.

As with phenotypical variation, and the shifting cultural meanings associated with the word "race," trans is an unstable analytical category (Goodman 2006). At the same time, the individuals discussed in this chapter represent a mode of sex/gender expression marginalized by contemporary heteronormative society, leading to a set of very measurable consequences, including a lack of health care, increased suicide rates, and/or workplace and housing discrimination. In other words, though conceptually fluid, transgender is a category that remains acutely material, and one that is often contoured by inadequate legal, medical, and juridical recognition. It is vital that those of us invested in both understanding and transforming the kinds of vulnerabilities that this population routinely confronts keep our analytical focus trained on both aspects of this shifting and dynamic identity.

Conclusion

Though it is impossible to predict what might constitute a transgender identity by the end of this century, it is likely that the one outlined in the previous pages is a mere skeleton of what is to come. As bodily sites upon and through which an increasing number of researchers are re-imagining contemporary gendered relations, the trans population signifies some of the latent possibilities still unrealized by both the feminist and LGB movements of the past decades (Valentine 2007). The daily lives of many transgender individuals are often lived in far less heady and radical terms, however. Mired in worlds that do not "fit" their own bodily experience(s), trans people are acutely and disproportionately challenged by societal expectations regarding gender presentation and expression. These daily struggles are eloquently summed up by the Transgender Foundation of America's (TFA's) Cristan Williams in a response to the murder of a trans woman in Houston in early 2010: "For most trans women who get ready to leave the house, for whatever reason, it takes about two hours to get ready. It's not to look like a diva, it's taking time to look passable so that you're not beaten or harassed…. You're spending that much time just to get out of your house, month after month, day after day. That is the reason why most of the clients we work with have symptoms of Post Traumatic Stress Disorder. [They] know[..] friends who've been beaten, murdered, [and they] fear[…] those things themselves."[19]

This grim reality is reason enough for demographers and social scientists to improve our understanding of the trans population. The kinds of concerns voiced by Williams can be effectively addressed by not only psychologists interested in PTSD or "niche" sexuality scholars, but by anthropologists, economists, legal scholars, or philosophers, in addition to interdisciplinary teams who

[19] Interview with Cristan Williams, director of the Transgender Foundation of America; Laura Richardson, SWGS conference 3/26/10 at Rice University. "Displacing and Distancing Myra Ical."

seek a more comprehensive understanding of the trans community. Demographers hoping to generate this research must be mindful of the issues raised in this chapter—inconsistent nomenclature, intra-population differences regarding inclusion and exclusion criteria, the full spectrum of bodily and lifestyle changes that correlate with a trans identity, invisibility and the choice to "go stealth," mistrust of researchers—as they formulate research questions and design methodological instruments. And as they grapple with the associated complexities of doing so, they can take heart that the trans community itself is in almost constant dialogue about these very issues. This was evidenced most recently for one of the authors by her participation in a days-long listserv discussion about the best ways to reformulate the line regarding sex/gender categories when formatting questionnaires: should it be an expanding series of boxes/choices? Should it be a blank space for the person to fill in?

Furthermore, in addition to the overt forms of violence described by Williams, transgender people face ubiquitous—and often more insidious—forms of structural violence every day; these include multiple forms of personal and institutional discrimination. Whether and to what extent transgender individuals are denied housing, bank loans, promotions, health insurance or healthcare, college admission, adoption services, or access to any part of the social safety net is a set of questions ripe for investigation. Moreover, it is critical that we investigate how these forms of discrimination articulate with other aspects of identity, including gender, race, socioeconomic class, and ability. The ways that these variables intersect can produce a number of distinct—and unequally experienced—"versions" of the category trans. There may be more differences than similarities, in other words, between an upper-middle class white male attorney who cross-dresses only in the context of a socially exclusive group and a trans man whose masculine identity feels compromised by his inability to afford a mastectomy. This means that it is vital, as it is with any categorical identity, that researchers working with this community remain cognizant that such differences amount to more than variations on a theme.

Trans people make plain the limits of a sex/gender binary; attentive researchers can use the experiences of this population to better understand how cis people are similarly limited by the notion that genitals and hormones make us either one *or* the other. Demographers can remember that the category "sex" is not that different from gender-coded bathrooms: each time it is measured or reported, it constrains a complex mix of variables and lived experience belied by the terms "male," "female," and even "other/trans." Noticing the ways that each of us participate in these conceptual and physical reductions is an important step in improving the representational capacity of our research with this (and other) populations.

Acknowledgements The authors would like to thank Jamison Green, Sean Moundas, Sari Reisner, Lauren Mizock, and Kristen Schilt for their thoughtful comments on earlier editions of this chapter.

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