

Nurse Practitioners: Accessing the Privilege to Competent Transgender Healthcare

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Introduction

Privilege and discrimination/marginality have been described as “divergent outcomes created by . . . institutional oppression” and “inseparable as codependent structural forces” (Case, Iuzzini, & Hopkins, 2012, p. 4). Privilege gives reference to automatic unearned benefits bestowed upon perceived members of dominant social groups based upon their social identity (Case, Izzini, et al., 2012; McIntosh, 1998, 2012). McIntosh (1998, p.1-2) described privilege as functioning as “an invisible weightless knapsack of special provisions, assurances, tools, maps, guides, codes, passports, visas, clothes compass, emergency gear, and blank checks.” Discussion of research of privilege lead to discrimination, disadvantage, marginality and oppression (Case, Izzini, et al., 2012). In today’s world, privileges are being denied to certain members of our society based upon their social identity -- more specifically, the privilege of competent healthcare is being denied to members of the transgender community.

The transgender (TG) community is difficult to define and understand for many people. Individuals who belong to this community have a clear desire to be identified with another gender that they were not born as at birth. Males feel innately that they are truly female and females believe that they are genuinely male. This intense yearning is very difficult for transgender individuals to manage, and due to this flux, they are even more vulnerable and marginalized by the healthcare system in the United States and across the world. TG individuals experience a higher level of health disparity including high prevalence of human immunodeficiency virus (HIV), sexually transmitted diseases, victimization, violence, mental health issues, suicide, and are less likely than heterosexuals (H), lesbians (L), gays (G), and bisexuals (B) to have health insurance (Lim, 2013).

Very little is known as to the true population of the transgender community within the United States. Some sources state that there is no real way to know, and others state that there are nearly 700,000 individuals or 0.3% of the adult population. To furthermore disrupt this potential statistic, an unknown amount of overlap exists within the transgender community, as they also identify as LGB (Grant, Mottet, Tanis, Harrison, Herman, & Keisling, 2011).

What is known is that is that their experiences with the healthcare system leave them marginalized, discriminated against, and left with a disparity. 17% of transgender individuals have been refused medical care due to gender expression; 5.4% are HIV positive, as compared to 0.6% of the general public, 29% postponed or cancelled needed medical care due to discrimination, and 36% attempted suicide, 22 times the 1.6% rate for the general population (Grant, et al., 2011).

The American Association of Nurse Practitioners (AANP): Standards of Practice for Nurse Practitioners (2013) identify that identify nurse practitioners (NP) as “licensed, independent practitioners who provide primary and/or specialty nursing and medical care in ambulatory, acute and long-term care settings” (p.1). Within this document nurse practitioners are required to follow a process of care including: assessing the health status of the patient, diagnosing the patient, developing a treatment plan, implementing the treatment plan, and following up to evaluate the patients status. Furthermore, the care priorities identified in the Standards of Practice for Nurse Practitioners (AANP, 2013) the NP promotes optimal health, provides continually competent care, allows for patient facilitation into the healthcare system, and promote a safe environment for their patients.

Due to the lack of nursing empirical and research knowledge available for the NP, complied with a lack of graduate curricular concentration in transgender healthcare, the NP faces

a very challenging time when attempting to care for the TG patient. The purpose of this paper is to, deconstruct myths regarding the TG community, give a basic knowledge of TG terminology and disseminate knowledge for NPs who have very little to no knowledge regarding the care of the TG patient.

Myths and Misconceptions Regarding TG individuals

We all encounter beliefs, assumptions about people, minorities, sexual risk factors, and causes of health issues and disparities. Through a careful examination to increase our awareness of our personal beliefs as healthcare providers, we are able to undertake a crucial step in providing culturally appropriate and sensitive care where transgender patients can feel included, acknowledged and comfortable with the care they receive. The following are myths or commonly held assumptions about transgender individuals.

Myth #1.

All transgender individuals are really gay or lesbian.

Truth. Sexual orientation is not the same as gender identity. Sexual orientation refers to the sex that you would prefer to share sexual relationships with as a sexual partner. Gender identity refers to the sex that the individual self-identifies with. As a friend in the transgender community said to me once, “sexual orientation is who you sleep with, but gender identity is who you go to bed as.” It was noted that the frequent addition of the ‘T’ to LGB speaks to the professional and public conflation that sexual minorities are shared under an umbrella of isolation, invisibility, and discrimination. However it is important to identify that there are different experiences that differentiate each minority group of the LGBT community in more important ways (Fassinger, Arseneau, Bieshke, Perez, & DeBord, 2007)

Myth #2.

All transgender people want or need sexual reassignment surgery (SRS).

Truth. No data exists to support the belief that all TG individuals want SRS. Literature back as far as 1971 indicates that SRS is neither indicated or desired for all male to female (MTF) transgender people (Randell, 1971). An 1987 study showed that the choice of SRS is not universal among MTF and female to male (FTM) transgender individuals (Kockott & Fahrner, 1971).

Myth #3.

All transgender people are at high risk for HIV.

Truth. The Centers for Disease Control (CDC) (2011) reported that the differences between being an individual at risk and being an individual from a population that has a high prevalence of HIV infection can falsely lead to the assumption that all transgender people are at higher risk. The CDC recommends that accurate data may be captured using an intake form that separates birth sex from gender identity. Furthermore, the CDC recommends that HIV behavioral prevention interventions be used with the transgender population (CDC, 2011).

Myth #4.

Transgender men (FTM) are not at risk for HIV infection because they only have sex with women.

Truth. McFarland, Thompson, and Raymond completed a study in 2011 in San Francisco of 59 FTM, of these 61% of FTM reported having sexual partners that were male in the previous twelve months, and 10% reported only having male sexual partners. It is important to note that this population has been significantly under represented in research, and assumptions about the sexual orientation of any person should not be made.

Myth #5.

Transgender persons don't need healthcare specific to being transgender.

Truth. The experiences, identities, and physical form among transgender individuals relative to non-transgender individuals create very different needs and strategies, and efforts must be directed toward the actual experiences of transgender people. Furthermore, research, policies, and materials need to be culturally relevant and specific (Lombardi, 2001). Kenagy found in 2005 from the results of a study of 182 transgender individuals in Philadelphia that 26% of respondents were denied medical care because they were transgender, and stated that lack of access to a doctor may hinder the general health of transgender people during the course of their lives. A 2013 documentary by Wichinski and Olson, "The T is No Longer Silent" gives insight into the real barriers that the transgender community experiences when attempting to access the healthcare system. Their stories are real, unique, and provide a vivid example of how the transgender community is marginalized by the health care system currently in place.

Transgender people are disproportionately impacted by other factors that impede their access to healthcare, including: poverty, unemployment, and homelessness. This population experiences more psychological distress, acts leading to distress, and structural challenges when compared to their dominant sexual and gender orientation counterparts. There is lack of societal and familial support; elevated risk for mental health and substance abuse; difficulty identifying viable role models for individual, couple and family development; and a lack of role models for sexual and gender identity development for individuals, couples, and families (Blumer, Green, Thomte, & Green, 2013).

In a 2011 survey of 6450 transgender people, 28% reported postponing medical care due to discrimination and another 48% were unable to afford healthcare. 28% of respondents were subjected to harassment in medical settings and 50% of respondents had to teach their medical

provider about transgender care (Blumer, Green, Thomte, & Green, 2013).

Myth #6:

Transgender people do not have different health risks than people who are not transgender.

Truth. Individuals who have undergone SRS but retain certain organs or tissues need careful follow-up for potential oncological problems commonly associated with their natal sex including: prostate, breast, cervical, and ovarian cancer. Transgender health has not been a focus of specialized clinical care because of an even greater lack of data and resources for lesbian, gay and bisexual individuals. Transgender individuals have struggled to have their clinical issues taken seriously and find appropriate resources for care (Mayer, et al., 2008). For a moving account of the experience of lack of access to healthcare for a FTM diagnosed with ovarian cancer, see the movie “Southern Comfort” (Davis, 2001).

Helpful Terminology in the Gender Diverse World

Gender Identity.

Individual’s internal sense of being male, female, both or neither. Gender diversity includes a full range of gender identities. Masculine men, feminine women, androgynous individuals, bi-gender persons, etc... (Transgender Educational Network of Texas, 2013).

Gender Expression.

Display, portrayal, and embodiment of gender mannerism, actions, behaviors, and roles. May be self-agency focused (i.e. Agentic), community focused (i.e. Communal) or any combination of the two. May be based on context. We all vary our gender expression depending on the role we are playing in society and situational modifiers (Transgender Educational Network of Texas, 2013).

Sex.

Primary anatomy and biology, determines whether someone is classified male, female, or intersex. Determination is somewhat social based in “accepted” biological factors and degree of masculinization. This may include chromosomes, hormones, and internal and/or external genitalia (Transgender Educational Network of Texas, 2013).

Intersex.

Individuals born that do not meet medical definitions of male or female based upon any variety of conditions. This would include chromosomal distinctiveness, hormonal diversity, and genitalia that are outside medically narrow definitions of what is a penis and what is a vagina (Transgender Educational Network of Texas, 2013).

Sexual Orientation.

Direction of one’s romantic and sexual attractions. An aspect of identity that is not based on gender identity/gender expression (Transgender Educational Network of Texas, 2013).

Cisgender.

Individual’s whose gender identity and/or gender expression aligns with societal expectations based on assigned sex at birth (Transgender Educational Network of Texas, 2013).

Transgender.

The term transgender is used as an adjective to describe one’s identity. It is used to describe an individual whose gender identity and/or gender expression is different from their assigned sex at birth. The term may include, but is not limited to, transsexuals, cross-dressers, and other gender diverse people. Transgender people may or may not decide to alter their bodies hormonally and/or surgically (Transgender Educational Network of Texas, 2013).

Gender Non-Conforming.

An adjective used to describe individuals who do not adhere to societal norms for

embodying gender (Transgender Educational Network of Texas, 2013).

Gender Privilege.

The term used to describe the subtle societal advantages for individuals who obey societal gender norms. Infraction of gender norms carries various societal penalties, including ostracism and stigmatization (Transgender Educational Network of Texas, 2013).

Considerations When Caring for TG patients.

General Guidelines.

Transgender patients in healthcare are best in an environment of trust. Familiarity with commonly used terms within the transgender community is essential for healthcare providers. As a care giver special attention must be made to protect the privacy and increase the trust between the patient and the healthcare provider. Reassure your patients about their confidentiality to positively increase the patient experience.

NPs should refer to their transgender patients by their preferred name and pronoun when addressing them, especially during difficult procedures (i.e. catheterization, intravenous start, suturing, incision and drainage, etc...). These preferred names and pronouns should be clearly marked on the chart so that there is continuity of care for all disciplines caring for the patient. One method that is used was to place the patients preferred name in brackets with their identified sex on their name band or medical record (John (Jasmine MTF) Smith). The clearer we are able to communicate the patient's needs throughout the healthcare team is a first step in providing transgender specific care. After ensuring that TG patients are identified and addressed properly and sensitively, the transgender patients wishes regarding potentially sensitive examinations must be respected at all times (i.e. pelvic exam, mammogram).

Providing Transgender Primary Care for the NP

The Transgender-Oriented Health History.

Any patient new to a healthcare provider should have a comprehensive medical history performed, especially so with the transgender patient. Specifically, the transgender health history should contain the following elements: general health history, family history, sexual health history, and a psychosocial history. It is important to complete a thorough obstetrical and gynecological evaluation of female to male patients because there may be an increased incidence of polycystic ovarian syndrome (PCOS) in this population (Bosonski, et al., 1997).

While completing the family history, particular attention should be paid to clotting disorders, cardiovascular disease, hypertension, diabetes, and mental illness. Also, cancers that are influenced by exogenous hormones should be considered: breast, ovarian, uterine, and prostate cancer. Consider more frequent screening for these patients that are taking masculinizing and feminizing hormones (Feldman, 2008).

A sexual history requires sensitivity for patients, and should be slowly worked in to through consecutive visits as the trust level develops with the patient. Sexual screening should be completed appropriately based upon the sexual history of the particular patient. Many transgender patients are in sexual relationships with other transgender patients. So there would no need for a pregnancy test for someone having a sexual relationship with a transgender man, as there is no sperm in the patient's body (Feldman, 2008). Consider each personally and their partners uniquely, as many situations will be different. It is also to introspectively reflect on your own values and assumptions before and while you are providing care for you transgender patients. You may think many thoughts, but they are not appropriate to discuss with your patient. Always remain sensitive to any patient in this vulnerable population.

The psychological history should be include the family history, economic history, social

environment, support sources, and sources of stress in your patient's life. Many of these factors can seriously impact your patient's life, and as their provider you need to be aware to assist your patients at all times (Feldman, 2008). Interestingly, a study completed by Cole, O'Boyle, Emory, and Meyer III (1997) found that there was no relationship between gender dysphoria and general psychopathological disorders. The findings were based from a sample of 435 patients, and identified that transsexualism is usually an isolated diagnosis and not part of any general psychopathological disorder. In fact, they also noted that patients with a preexisting psychological disorder prior to transition eliminated that disorder upon transitioning to their desired gender.

The Transgender Physical Examination.

The physical examination of the transgender patient should be focused on the organs that are present in the patient rather than the sexual identity of the patient. Many transgender patients feel uncomfortable with their bodies, and may consider parts of the physical examination traumatic (Wichinski & Olson, 2013). It is of the utmost importance to delay examination of the sexual organs and breast areas until a strong clinical patient rapport has been established. The best method to approach the sensitive physical examination areas are to allow for the patient to direct the clinician in the examination, while allowing for the clinician to be thorough. The clinician must completely explain the purpose and techniques utilized in the examination prior to examining the patient (Feldman, 2008).

There are a range of clinical findings that are unique to transgender patients who are undergoing feminizing or masculinizing hormone replacement therapy. FTM patients may have beard growth, clitoromegaly, acne and androgenic alopecia. Also FTM patients who have bound their breast may have skin infections under their breasts. MTF patients will have breast

development, underdeveloped nipples, minimal facial and body hair, testicular shrinkage, and possible herniation of the inguinal canal due to the practice of “tucking” of the testicles to hide their presence.

In postoperative patients the physical findings will change according to the types and amounts of surgical procedures that the patient has experienced. FTM patient may have scars from mastectomy and large or small grafted nipples. The neophallus in the FTM created from the release of an augmented clitoris (metaidioplasty) appears like a small penis, but the grafted penis from phalloplasty will be adult sized but more flaccid than a natal males penis. In these patients erections may be attained and maintained through the use of a stiffner or pump. MTF patients may have breast implants, testicular and penis removal with the creation of a neovagina (vaginoplasty). The labia and vaginal hood may have varying degrees of construction, depending upon the surgical revisions. The neovagina is less moist than natal women and may be internally stenosed if not dilated daily or maintaining sexual activity (Feldman, 2008).

Primary Transgender Care.

Primary prevention and screening should be performed as a practitioner would do in any patient, based upon their history, family history, age and organs that are present in their patient. For example, a FTM patient with a history of cervical cancer should be screened according to guidelines for natal females (Lawrence, 2005). Most other screenings for diseases should be performed as one would do for any patient seen by their primary care provider.

There are many options for transgender patients to obtain treatment for gender dysphoria. These include changes in gender expression and role; hormone replacement therapy, surgical procedures to change sexual characteristics, and psychotherapy (Rachlin, Hansbury, & Pardo, 2010). All transgender patients need to pursue an extensive exploration of family, social, and

psychological issues pertaining to their health prior to transitioning – despite their age. In early childhood, children may state that they want to make a transition from their natal gender long before puberty. This is a controversial issue that has divergent views from many health professionals. Currently no evidence exists demonstrating the outcomes of early social transitions for transgender children. Adolescent transgender patients have three categories or stages of interventions (Hembree et al., 2009). These include fully reversible interventions, partially reversible interventions and irreversible interventions. Fully reversible interventions include the suppression of estrogen or testosterone production with GnRH analogues, and thereby delaying the physical changes of puberty. Partially reversible interventions include hormone replacement therapy (HRT) to masculinize or feminize the body. Some of the changes brought about by HRT may need reconstructive surgery to reverse (i.e. gynecomastia), while other changes will be irreversible (i.e. deepening of the voice). Finally, irreversible interventions include surgical options. The partially reversible and fully reversible options are available for the adult transgender patient. For the primary care provider of transgender patients, it is of utmost importance to understand hormone replacement therapy of the adult patient. HRT in adolescents should be only considered by someone who is very familiar with HRT or send the transgender patient to a pediatric endocrinologist (Hembree et al., 2009).

Hormone Replacement Therapy.

Feminizing and masculinizing HRT is performed through the exogenous administration of hormones, and is medically necessary for many transgender and gender non-conforming individuals (Newfield, Hart, Dibble, & Kohler, 2006; Pfafflin & Junge, 1998). Studies regarding the outcomes of feminizing and masculinizing interventions have reported an improvement. However, the majority of the outcomes research has been completed with individuals who had

undergone sex reassignment surgery. Currently there is a literature gap in research regarding outcomes of transgender patients that undergo HRT without sex reassignment surgery (Institute of Medicine, 2011). HRT must be individualized to the individuals goals, risk/benefit ratio, the presence of other medical conditions, and consideration of social and economic issues. HRT is able to provide significant treatment for transgender patients who do not wish to have sex reassignment surgery or cannot (Meyer, 2009).

The initiation of HRT needs to meet certain criteria. These criteria include: persistent well documented gender dysphoria, the ability to make an informed decision and consent to treatment, be of legal age or have parental consent, and have all medical and mental health concerns well controlled. Usually a psychological assessment has been completed and the patient does present with gender dysphoria. However, in certain circumstances it is acceptable practice to provide hormones to patients who have not met these criteria. An example is that a patient who has been taking hormones unsupervised illegally living in their desired gender decides to seek your services for monitoring their status and providing hormones of a known quality. Furthermore, it is unethical to deny someone hormone therapy on the basis of the seropositivity of blood borne infections such as human immunodeficiency virus (HIV) and hepatitis (Meyer, 2009).

Once the patient has begun HRT for masculinizing or feminizing themselves physical changes will occur. For FTM patients the following are expected as a result of the HRT: deepened voice, clitoral enlargement, growth of facial and body hair, cessation of menses, atrophy of breast tissue, and decreased percentage of body fat compared to lean muscle mass. For MTF patients there are expected results from HRT including: breast growth, decreased erectile function, decreased testicular size, and increased percentage of body fat to lean muscle

mass. The majority of the changes that occur take place over a period of two years. The degree and rate of physical changes has no evidence to support that any approved type or method of HRT is more effective than any other in producing the changes. The following table identifies the risks associated with HRT.

Table 1. Risks Associated with HRT

Risk Level	Feminizing Hormones	Masculinizing Hormones
Likely increased risk	venous thromboembolic disease gallstones elevated liver enzymes weight gain hypertriglyceridemia	polycythemia weight gain acne androgenic alopecia sleep apnea
Likely increased risk with presence of additional risk factors.	cardiovascular disease	
Possible increased risk	hypertension hyperprolactinemia	elevated liver enzymes hyperlipidemia
Possible increased risk with presence of additional risk factors	type 2 diabetes	destabilization of certain psychiatric disorders cardiovascular disease hypertension type 2 diabetes
No increased risk or inconclusive	breast cancer	loss of bone density breast cancer cervical cancer ovarian cancer uterine cancer

With appropriate training, feminizing/masculinizing HRT can be managed by a variety of providers including nurse practitioners (Dahl et al., 2006). These type of office visits allow for an opportunity to deliver broader care to a population that is medically underserved (Feldman, 2007). Many of the tasks of screening patients and management of comorbidities associated

with long term hormone use fall more within the scope of practice of primary care rather than specialist care, particularly in locations where dedicated gender teams or specialized physicians are not available (World Health Organization, 2008). In general healthcare providers who provide HRT should: perform an initial evaluation including the discussion of the patients physical transition goals, health history, physical exam, risk assessment, and relevant lab tests; discuss with patients the expected effect of HRT and the possible adverse effects; confirm patients have the capacity to understand the risks and benefits of HRT; provide ongoing medical monitoring of the patient; communicate with the patient's primary provider, mental health professional, and surgeon; and if needed, provide patients with a medical statement that they are under medical supervision and care that includes HRT (Meyer, 2009).

Currently there are no clinical trials of HRT that have been conducted to evaluate the safety or effectiveness of masculinizing/feminizing HRT. There exists a wide variation in the medical literature of hormone regimens (Morre et al., 2003; Tangpricha et al., 2003; van Kesteren, Asscheman, Megens, & Gooren, 1997). For these reasons the World Professional Association for Transgender Healthcare (WPATH) does not recommend or endorse a particular regimen, but believe that the treatment regimen should be designed for the patients, economic, social, and even geographical location. With the advance of telemedicine and modern technology, TG patients may now be able to receive quality healthcare without regard for geographical location. Through the use of telemedicine and modern technology, I am able to care for TG patients throughout the state regarding their HRT.

Regimens for feminizing hormone therapy (MTF). There are three classes of medications that are used for feminizing transgender MTF patients: estrogens, progestins, and androgen-reducing medications. The use of estrogen, specifically estradiol, increases the

feminization of the transgender patient. However, oral estradiol does increase the risk for venous thromboembolism (VTE), so it is recommended that transdermal or injectable estradiol be used to prevent this side effect (Hambree et al., 2009). However, due to the poor socioeconomic status of many transgender patients, they cannot afford the transdermal and injectable forms. The oral estradiol is effective and relatively inexpensive, but the practitioner must make the patient aware of the increased risk for VTE. Some patients may not be able to safely take the dosage of estrogen to achieve the desired results, and this possibility needs to be discussed with patients before commencing HRT (Hambree et al., 2009).

The usage of progestin with estrogen in feminizing HRT is controversial (Oriel, 2000). Some practitioners believe that because of the role progestin plays in mammary development that it is necessary to give for breast development. However, Meyer (1986) completed a clinical comparison of feminization regimens with and without progestin, and the results noted that there was no enhanced breast growth or decreased testosterone levels with the use of progestin. Some concerns regarding progestin use is depression, weight gain, and lipid changes (Meyer et al., 1986).

Androgen-reducing medications combined with estrogen are the most commonly used feminizing regimens for MTF transgender patients. These medications reduce the levels of endogenous testosterone, and with this effect minimize masculine characteristics of the patient. They also allow for a smaller dose of estrogen to be needed to achieve the patients desired transition (Prior, Vigna, & Watson, 1989). Commonly used anti-androgenic agents include spironolactone, cyproterone acetate, GnRH agonists and 5-alpha reductase inhibitors. Spironolactone directly inhibits testosterone secretion and androgen binding to the androgen receptor; GnRH agonists block the gonadotropin-releasing hormone receptor, thus blocking the

release of follicle stimulating hormone and luteinizing hormone (very expensive injectable or implant); and 5-alpha reductase inhibitors block the conversion of testosterone to the more active agent 5-alpha-dihydrotestosterone thus benefitting scalp hair loss, body hair growth, sebaceous glands and skin consistency (Hembree et al., 2009).

Regimens for masculinizing hormone therapy (FTM). The primary agent used for masculinizing HRT is testosterone. Testosterone can be administered in many ways – sublingually, intramuscularly, and transdermal. There is evidence that the transdermal and the intramuscular doses of testosterone achieve similar masculinizing results. Again the goal is to use the lowest dose possible to achieve results. Progestin may be useful when initiating FTM transition HRT in that it will allow for the patients' menses to cease. Usually this is used for a short time until the testosterone replacement levels are adequate (Hembree et al., 2009).

Currently there are a lot of bio-identical hormones being used for HRT. To date, there is no evidence that suggests that bio-identical hormones achieve better results or safer results than synthetic hormones (Sood, Shuster, Smith, Vincent, & Jatoi, 2011). Personally, administering both to patients of the same age at the same time have had similar results in both masculinizing and feminizing HRT for my transgender patients. Furthermore, my patient's testosterone and estrogen levels have maintained on a quarterly basis with minimal amounts of each and the correct blockers in place.

The transgender community faces significant marginality and discrimination when attempting to receive competent healthcare services due to a lack of knowledge and understanding of their unique medical needs. This distance can only be shortened by primary care providers having competency in transgender care for nurse practitioners. As nurse professionals we have taken the lead in HIV care in the past, today we have an opportunity to

make a difference with the transgender community by giving the privilege of access to culturally competent transgender care.

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