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Creating, Reinforcing, and Resisting the Gender Binary: A Qualitative Study of Transgender Women's Healthcare Experiences in Sex-Segregated Jails and Prisons

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Abstract

Purpose—Incarcerated transgender women often require healthcare to meet their physical-, mental-, and gender transition-related health needs; however, their healthcare experiences in prisons and jails and interactions with correctional healthcare providers are understudied.

Design/methodology/approach—In 2015, 20 transgender women who had been incarcerated in the United States within the past five years participated in semi-structured interviews about their healthcare experiences while incarcerated.

Findings—Participants described an institutional culture in which their feminine identity was not recognized and the ways in which institutional policies acted as a form of structural stigma that created and reinforced the gender binary and restricted access to healthcare. While some participants attributed healthcare barriers to providers' transgender bias, others attributed barriers to providers' limited knowledge or inexperience caring for transgender patients. Whether due to institutional (e.g., sex-segregated prisons, biased culture) or interpersonal factors (e.g., biased or inexperienced providers), insufficient access to physical-, mental-, and gender transition-related healthcare negatively impacted participants' health while incarcerated.

Research implications—Findings highlight the need for interventions that target multi-level barriers to care in order to improve incarcerated transgender women's access to quality, gender-affirmative healthcare.

Originality/value—This study provides first-hand accounts of how multi-level forces serve to reinforce the gender binary and negatively impact the health of incarcerated transgender women. Findings also describe incarcerated transgender women's acts of resistance against institutional and interpersonal efforts to maintain the gender binary and present participant-derived recommendations to improve access to gender affirmative healthcare for incarcerated transgender women.

INTRODUCTION

Transgender women, individuals assigned a male sex at birth who now have a feminine gender identity or expression, experience pervasive stigma in the U.S. (White Hughto et al., 2015). Stigma restricts access to resources for transgender women, including employment and housing, leading some to turn to street economies, such as survival sex work, or substance use to cope with mistreatment; these activities then place transgender women at risk for arrest and incarceration (Garofalo et al., 2006, Grant et al., 2011, Nemoto et al., 2011, Mizock and Mueser, 2014). Biased policing and sentencing practices also contribute to high rates of incarceration among transgender women (Wolff and Cokely, 2007, Grant et al., 2011). Lifetime estimates of incarceration range from 19% to 65% among transgender women (Reisner et al., 2014, Garofalo et al., 2006, Clements et al., 1999, Grant et al., 2011), compared to less than 3% of the U.S. general population (Glaze and Kaeble, 2014). Once incarcerated, transgender women are typically housed in sex-segregated facilities according to their genitalia; thus, transgender women who have not had gender confirmation surgery are placed in male facilities where they are at-risk for mistreatment (Jenness et al., 2009, Emmer et al., 2011, Lydon et al., 2015).

Due to the stigma attached to their feminine gender identity and/or expression, transgender women incarcerated in male facilities are especially at risk for verbal harassment, physical violence, and sexual assault (Jenness et al., 2007, Jenness et al., 2009, Emmer et al., 2011, Lydon et al., 2015). While victimization often occurs at the hands of inmates, transgender women also report being victimized by jail and prison staff. For example, a U.S. study of 6,450 transgender individuals found that among 749 transgender women in the sample who had been incarcerated, 38% had been harassed, 9% had been physically assaulted, and 7% had been sexually assaulted by facility staff (Grant et al., 2011). While research points to mistreatment by custody staff, a dearth of empirical research explores the nature of transgender women's interactions with healthcare providers (e.g. doctors, nurses, psychologists, counselors).

Like all detainees, incarcerated transgender women may need to access physical and mental health services to meet their preventative, chronic, and urgent healthcare needs; some transgender women also require medical care in order to "transition" or medically affirm their gender. Medically affirming ones gender can include the use of exogenous hormone therapy (e.g., estrogen) or surgery (e.g., medical confirmation surgery) to feminize the body, with hormone therapy often being the first and sometimes only gender transition-related intervention sought (Coleman et al., 2012). Hormone therapy is an essential component of healthcare delivery for some transgender people, as it alleviates the psychological distress of gender dysphoria (APA, 2008, Coleman et al., 2012), and has been linked to improved mental health outcomes (e.g., reduced depression and anxiety) and quality of life (White Hughto and Reisner, 2016, Murad et al., 2010). Given that transgender women may require a variety of health services while incarcerated, access to supportive medical providers, who are knowledgeable about transgender individuals and their healthcare needs, is essential to ensuring the health of incarcerated transgender women.

The extent to which transgender women are able to access quality, gender-affirmative general and gender transition-related care while incarcerated is not well-documented in the empirical literature. Prior qualitative research in non-criminal justice settings highlights providers' lack of training on how to provide gender-affirmative care to transgender patients, and transgender women consistently report provider bias and limited transgender-specific healthcare knowledge as a barrier to receiving adequate healthcare (Lurie, 2005, Poteat et al., 2013). In regards to healthcare in criminal justice settings, a 2014 survey of 1,118 lesbian, gay, bisexual, transgender, and queer (LGBTQ) detainees from across the U.S. found that 21% of respondents were treated disrespectfully by correctional medical staff and/or therapists; however, the report did not define the term "disrespect" and the experiences of transgender respondents were not reported separately from non-transgender respondents. Similarly, a 2009 survey of 59 transgender and gender-variant inmates in Pennsylvania found that 42.4% of the sample believed their needs were not taken seriously by medical staff, however, the survey did not report the experiences of transgender women separately from the full sample. Like the national study, the Pennsylvania study relied primarily on quantitative methods, which precluded the nuanced exploration of unique participant experiences. Further, a dearth of empirical research qualitatively explores key interpersonal or provider-level factors that may shape the delivery of care, such as provider comfort, attitudes, and knowledge about transgender people or their care.

While interpersonal factors may contribute to access to care barriers, structural or institutional factors (e.g., culture, norms, practices, and policies) may also shape the delivery of care for incarcerated transgender women. In terms of transgender-specific correctional policies, an investigation found that only 16 out of the 26 U.S. states surveyed had explicit policies enabling transgender individuals to continue hormone therapy once incarcerated and only four states had clear policies allowing transgender inmates to initiate hormones under certain circumstances (Brown and McDuffie, 2009). Further, research with transgender people from across the U.S. suggests that prison policies often translate into restricted access to hormones. For example, a survey of 27,715 U.S. transgender people found that 37% of the 321 participants who had been incarcerated in the last year and were taking hormones prior to incarceration were prohibited from continuing their hormones while incarcerated (James et al., 2016). When examining hormone access among transgender women specifically, a U.S. study found that 24% of the 749 transgender women in the sample who had been incarcerated in their lifetime had been denied hormone therapy while incarcerated. While these studies offer important insights into the prevalence of hormone access barriers faced by transgender individuals in prison, they do not provide an in-depth exploration of how these barriers are personally experienced by transgender women specifically. Qualitative research that explores how transgender women navigate prison policies and explores the role of institutional culture in the delivery of care is necessary to inform intervention efforts that are responsive to the needs of incarcerated transgender women.

Despite transgender women's documented need for general and transition-related healthcare while incarcerated, a dearth of research has examined the structural and interpersonal barriers to gender-affirmative healthcare from the perspectives of transgender women themselves. Guided by the socio-ecological model (Bronfenbrenner, 1994), the present study utilizes interviews with formerly incarcerated transgender women to: [1] assess their

experiences receiving physical-, mental-, and transition-related healthcare in correctional settings; and [2] document potential structural, interpersonal, and individual barriers to healthcare that can be targeted in future, multi-level intervention efforts to ensure access to quality, gender-affirmative care for incarcerated transgender women.

METHODS

Sample

Semi-structured interviews with 20 formerly incarcerated transgender women were conducted between July and August 2015. Participants were recruited through multiple purposive sampling strategies, which included posting paper and electronic recruitment flyers at community organizations and transgender-specific websites and list-serves. Eligible participants were age 18 years and older; self-identified as a transgender woman, transsexual woman, or female who was born male, or on the trans-feminine or male-to-female spectrum; assigned a male sex at birth; and had been incarcerated in a U.S. jail or prison within the past five years for one week or more.

Procedures

After providing written informed consent, participants completed semi-structured interviews assessing their experiences accessing healthcare while incarcerated, including individual (e.g., healthcare avoidance), interpersonal (e.g., patient-provider dynamic, provider attitudes and knowledge) and structural factors (e.g., institutional policies and practices). The one-on-one, in-depth interviews lasted approximately 45–60 minutes and were conducted by the first author, who has extensive experience conducting community-based research with transgender women. The interviews were audio-recorded and transcribed verbatim. Participants also completed a brief survey via pen and paper, which assessed participant demographics, incarceration history, and healthcare utilization during and prior to incarceration. To protect anonymity, participant names were changed. Participants received a \$50 gift card as compensation. The study was approved by the Institutional Review Board of Yale University.

Data Analysis

Participant interviews were coded and analyzed using an iterative and inductive approach borrowed from grounded theory (Strauss and Corbin, 1997). The first author began by open-coding the transcripts for broad analytic themes. Codes were subsequently grouped into categories and compared to each other in the process of constant comparative analysis. After creating an initial codebook, the first and second authors and a trained third researcher coded six transcripts using Dedoose software (Lieber and Weisner, 2010). Coded transcripts were then compared and modifications were made to improve clarity and reduce codebook redundancies. Upon finalizing the codebook, the first author coded all the interviews, which were then double-coded by the two other coders (ten transcripts each). The coders and authors met frequently throughout the coding process to discuss any uncertainties in code application and ensure consistent application of codes across transcripts.

Theoretical Framework

In organizing the coded transcripts into written results, the authors drew on the socio-ecological model, which was first developed by Bronfenbrenner (1994) to explain how multiple systems beyond the individual shape human development and was later adapted and applied to numerous health-related outcomes (Baral et al., 2013, Link and Phelan, 2006, Auerbach et al., 2011). Recently, the socio-ecological model was adapted to describe the structural- (institutions, culture, policies), interpersonal- (interactions with others), and individual- (behavioral reactions, beliefs, and coping responses of transgender individuals) levels at which transgender stigma is produced, enacted, and managed to ultimately influence health (White Hughto et al., 2015). This conceptual model describes a bidirectional relationship between factors at each level such that structural factors can influence interpersonal interactions, which can in turn shape individual behaviors and vice versa. The present study extends the application of the socio-ecological model of transgender stigma to describe transgender women's experiences receiving healthcare in correctional settings (See Figure 1).

RESULTS

Participant Characteristics

Participant characteristics are reported in Table 1. Briefly, participants' mean age was 36.9 years (SD=10.0) and the majority (70.0%) were women of color, had a high school degree or less (75.0%), were unemployed or on disability (90.0%), and earned less than \$18,000 annually (95.0%). Participants had been incarcerated an average of 8.2 times (SD=6.9) and most had been incarcerated in county jails in one or more New England states, including Massachusetts, Rhode Island, Connecticut, and Maine.

Participant Narratives

Findings from participant narratives are presented in the top portion of each concentric circle (above the circle titles) of the adapted social-ecological model shown in Figure 1. In the sections below, we draw from participant narratives to describe transgender women's experiences accessing physical-, mental-, and transition-related healthcare in male correctional facilities and describe how these experiences relate to the creation, reinforcement, and resistance against the gender binary (i.e., the classification of sex and gender into two distinct and opposite categories of male and female, masculine and feminine (Fausto-Sterling, 2012)). Utilizing the socio-ecological model, we describe how the gender binary is created at the structural-level (institutional culture and policies relating to gender identity and expression) and reinforced at the interpersonal-level (provider interactions with transgender women). At the individual-level (transgender women's beliefs and behaviors), we describe the ways in which transgender women reinforce or resist the gender binary, with implications for health. We then conclude with participants' recommendations to improve correctional healthcare through behavioral, educational, and policy efforts that aim to resist or dismantle the gender binary at each level of the institutional environment. Pseudonyms are utilized in presentation of these data.

“This is not a Girl’s Unit” – The Institution’s Role in Creating the Gender Binary at the Structural-Level

Recently incarcerated transgender women described the sex-segregated structure of jails and prisons and the experience of being housed in a male facility according to their genitalia. Taylor, a 50-year-old participant described the prison systems’ disregard for transgender inmates’ feminine gender expression noting: They don’t care if you got a beautiful face. Beautiful breasts, beautiful hips, beautiful legs, beautiful voice, feminine personality. If you got [a penis]... You’re going to a men’s prison.” Similarly, Abby, a 28-year-old participant, described the institutional focus on genitalia over gender identity: “Because I’m still physically male, and in the eyes of the [state] if you’re physically male, you’re gonna be put on the men’s side, even if you identify as female.”

In the sex-segregated environment of male correctional facilities, feminine gender expression was viewed as “abnormal” and participants described being controlled, belittled, and demoralized as a result. Institutional concerns about femininity were often enacted into policies that restricted inmates from having a feminine gender expression. For example, Elle, who had been incarcerated for a total of 5 years, described the enforcement of prison policies designed to restrict feminine gender expression among inmates in male facilities: “If you ran your hair through an elastic, and put it in a ponytail, some of the officers be like, ‘Do not, this is not a girl’s unit. Take that out of your head.’” The enforcement of policies that favor masculinity and trivialize the feminine gender expressions of transgender women were also described by Ebony, who had been incarcerated for a total of 6 months. Here, she recalls how custody staff reacted to transgender women’s feminine gender expression, noting: “They would do whatever they could to like, dismantle your femininity. Like if you had a wig on, they’ll take your wig off. They’d laugh at your clothes, stuff you’d be wearing, they made it a huge point to say ‘you’re a male,’ you know, they pick at you.” In addition to describing the existence of policies and practices that maintain the gender binary by forcing conformity to masculine gender norms, Elle and Ebony’s quotes highlight an institutional culture in which transgender women are regularly ridiculed for having a feminine gender expression, a theme that emerged across interviews.

Restrictive policies regulating access to transition-related medical care served as another means through which male correctional facilities sought to maintain the gender binary. Indeed, nearly all participants noted that hormone therapy could only be obtained if they provided sufficient documentation showing that they were prescribed hormone therapy prior to incarceration. Abby, who had not been using hormones prior to being incarcerated for two months, noted: “I wasn’t even allowed to have my hormones. I was trying to get on them when I went in, but they wouldn’t give them to me. You had to be on them when you were on the outside.” Abby was not alone in facing challenges accessing hormone therapy, as participants who had been on hormones prior to incarceration also described structural barriers to care. For example, Taylor, who had been homeless prior to being incarcerated for two years, described the challenges she faced providing sufficient documentation of her prior hormone use:

I told them, ‘please, I need my hormones.’ Nope, no hormones. ‘you gotta get a letter from your doctor.’ How am I gonna get my letters? How am I gonna call my

doctor? I don't have nobody to call. My parents are dead. I didn't have no information...no numbers...I didn't have nothing.

Like many other participants, Taylor's inability to document her hormone use according to institutional standards (i.e., verification of prescription by an outside physician) restricted her access to hormones in prison. Taylor's quote also highlights how hormone documentation requirements are particularly challenging for unstably housed individuals as well as those who lack social support on the outside – a common theme among the sample's more marginalized participants.

Participants who had been taking street hormones outside of a physician's care also faced significant barriers to continuing hormone therapy once incarcerated as "street hormones" were not recognized as legitimate according to prison policies. Brandy, a Black participant who had been taking street hormones for 10 years prior to being incarcerated for 3 months, described the implications of hormone-related correctional policies: "I didn't have a prescription for hormones, so they wouldn't give me any." Similarly, Elle a White participant described her experience trying to access care during her longest, 2 year sentence, noting: "No, no, no. They're saying I'm not trans - even though I was transitioning. I was doing it on the outside, but they stopped my hormones because I was doing street hormones." While Elle had been incarcerated for a longer period of time than Brandy, their quotes illustrate that incarceration length had no barring on ability to access hormones if prior hormone use could not be verified. Elle's quote also highlights how prison policies served to erase her transgender experience, reinforcing the gender binary and making her invisible in a male facility.

Participant narratives highlight how the sex-segregated structuring of the institution rendered them "abnormal" and fostered an institutional culture in which transgender women, and feminine expression more generally, are stigmatized. Transgender stigma appeared to be further embodied in the policies of the correctional institution, which forced transgender women to conform to male gender norms by limiting their use of female hormones and restricting their feminine gender expression (e.g., hair style, clothing).

"What is this – Conversion Therapy?" – Provider's Role in Reinforcing the Gender Binary at the Interpersonal-Level

Providers regularly reinforced institutional policies and practices that stripped transgender women of their femininity. Participants described primary care providers' attempts to maintain the gender binary by creating barriers to accessing feminizing hormones. For example, Sierra, a 49-year-old participant who had been incarcerated for a total of 5 years, recalled providers' roles in delaying her access to hormones:

It took me a [long time] to get my hormones this last time I was in jail because they had to go through all this paperwork and madness. The [providers] would send a paper and call the hospital, but then say they can't get in touch with my doctor. They kept on putting it off, and putting it off, and putting it off. It took me months to be able to get my hormones.

Several participants reported that providers disregarded the importance of hormone therapy, which led to inadequate care. For example, Chrissy, who had been incarcerated less than a month and who had been prescribed hormones prior to being incarcerated, described her experience trying to receive her full dose of hormone therapy, stating: “They kept skipping doses, ‘cause I was supposed to get them four times a day, and I’m like, okay, I need my hormones. Then they go and give it to me like twice a day. But they would give me my psych meds though.” Similarly, all of the participants who sought treatment for HIV (n=5) during their last prison or jail stay were able to easily access care; however, several reported challenges accessing hormones. For example, when asked about whether she was able to receive her HIV medications, Elle, who had been incarcerated on and off for a total of 5 years, stated: “Yeah, I didn’t have an issue with medical.” However, when asked about hormones specifically she stated: “Uh no, no, no, no,” as she had been on street hormones prior to incarceration and therefore wasn’t able to access hormones while incarcerated. Several participants attributed inadequate access to hormone therapy and the prioritization of other medications over hormones to providers’ perceptions that hormone therapy lacks a significant health benefit. For example, Ebony, who had been incarcerated for 6 months, noted: “Being a trans woman in jail, like, they kinda brush stuff like hormones aside. They’d wait ‘til you are absolutely gonna die before they do anything.” Ebony’s quote suggests that providers may be unaware of the physical and psychological benefits of hormones or may perceive hormones to be less medically necessary than medications for other health conditions (e.g., HIV/AIDS, psychiatric conditions).

Participants indicated that some providers used the threat of gender-based violence by inmates and staff as a rationale for withholding transgender women’s access to hormones. Ebony recalled her most recent 6-month sentence when she was briefed by a doctor about the dangers of being a transgender woman in a male facility, noting: “The doctor came and talked to me and said that because I’m transgender that I could be raped. I could be physically harmed.” Correctional institutions are tasked with ensuring the safety of inmates; thus, the femininity of transgender women in male facilities poses challenges for the institution, challenges that providers often play a role in managing. Cassandra, who had been incarcerated for 2 years, described providers’ attempts to maintain the gender binary as a means to control the threat of victimization, she noted: “They really don’t want to give [hormones]. They’re too afraid we might blossom into beautiful women.” Cassandra’s quote suggests that providers’ fears regarding the consequences of being visibly feminine in a male facility may ultimately drive providers’ decision to deny transgender women access to hormones.

Not all participants described such paternalistic “benevolence” on the part of healthcare providers. Several participants instead described outright mistreatment on the part of medical and mental health providers that derived from transgender bias. For example, Sabrina, a Latina participant who had been incarcerated for a total of 4 years, described a healthcare environment in which transgender individuals were consistently treated poorly, saying: “It’s like once the [providers] see you’re transgender, they treat you like shit.” For some participants, mistreatment by healthcare providers included a lack of respect for one’s feminine gender identity such as the repeated use of male pronouns. For example, Tina, a White participant who had been incarcerated more than 20 times for short periods of time

(no more than 3 months at a time), described encounters with a mental health counselor who regularly mis-gendered her:

Being called 'he', 'him', 'sir' and all this. I said, 'What is this, conversion therapy?' And the counselors kept doing it. I'd state, 'I'm transgender' and they just kept on with this 'sir' stuff, and I was like, 'Is this conversion therapy?'

Tina experienced the regular act of being mis-gendered by providers as an attempt to reinforce the gender binary by forcing her to embrace a male gender identity as a form of conversion therapy. Experiences of provider mistreatment were also described by Ebony, a Black participant who spent 6 months in prison: she stated: "The nurse, she makes it a point to defeminize you. They say things like, 'you're not a girl, you're a he.' They would say very derogatory things just to break your spirit." In addition to noting a nurse's attempt to force her into the gender binary, Ebony's quote also described the ways in which the behavior of healthcare providers had the potential to negatively impact her mental health.

While some participants often attributed provider mistreatment to transphobia, other participants linked their poor interactions with providers to a lack of knowledge about how to appropriately meet the needs of transgender people. For example, in describing her overall perception of healthcare in prison, Tina noted: "I mean it's just down there [in the medical unit], the providers are not educated on the transgender issue at all." Providers often demonstrated their lack of knowledge and exposure to transgender patients via their attempts to "study" transgender patients, experiences which many transgender women found discomforting. For example, Evy, a Latina participant who had been incarcerated for less than a year, recalled an initial evaluation in which providers scrutinized her feminine gender expression:

I felt like it's still in unsure waters. People were unsure about the whole [transgender] thing. It was so foreign, so new to them, where everybody was making decisions first out of nervousness maybe or liability-wise. Like, 'what should we do?' Like, 'oh my God, maybe you should go talk to the psychiatrist.' Then this woman came with a recorder. And I'm just like, 'oh my God, do I really need a recorder?' I'm sure I'm not the only one that has panties, honey.

while Evy noted that she was not the only woman in the male facility where she was housed, her quote suggests that her femininity generated anxiety on the part of providers who lacked prior exposure to transgender women. According to Evy and others, providers' anxiety around how to care for transgender patients often led providers to treat transgender patients as phenomena to be studied rather than human beings in need of supportive and affirmative care.

The limited knowledge of healthcare providers was also demonstrated by reports that providers consistently asked transgender patients invasive questions about their bodies and medical and life histories. For example, Brandy recalled medical encounters in which medical and mental health providers regularly asked her to educate them on transgender health:

They asked a lot of questions. I was kind of like the token tranny and answered most of them because there was nothing else to do. It was a little embarrassing.... but after a while, you're gonna like, just ignore it.

Brandy's quote highlights how providers' limited knowledge regarding transgender health places a burden on transgender women receiving care in jails and prisons and fosters a sense of uneasiness in an already oppressive institutional setting.

While participants overwhelmingly described their healthcare interactions as not being affirming of their gender, a handful of participants described satisfactory or even positive interactions with healthcare staff. For example, Cassandra, who had been incarcerated for 2 years, noted that the: "people who worked inside the infirmary weren't too bad." Alicia, who had been incarcerated for a year, indicated that there were a few nurses with whom she felt comfortable seeking out care, but others she specifically avoided based on the experiences of other trans women. She noted: "There was one or two nurses that I was fine with. The rest of 'em I didn't really like. They were just really rude. But I paid attention to the other trans girls, so I knew who to go to and who not to go to." Incarcerated on and on off over the course of 4 years, Sabrina was the only participant to describe a fully supportive relationship with healthcare staff. In comparing her interactions with various staff members, she noted: "Well most of the guards are pigs, but the counselors would come around. I would talk to them and I felt talking to them, and well, I felt safe." These quotes illustrate that while bias and lack of transgender health knowledge exist among the correctional healthcare providers with whom transgender women in this sample interacted, there were a handful of providers that were able to meet patients' physical and mental health needs.

"I Just Wasn't Willing to Give Up my Femininity" - Transgender Women's Agency in Resisting the Gender Binary at the Individual-Level

Participants' prior and anticipated experiences of mistreatment in correctional settings, including with healthcare providers, shaped their behavior while incarcerated. For some participants, the fear of being treated poorly by providers, custody staff, and other inmates led them to conform to male gender norms and reinforced the gender binary, while others actively resisted the gender binary by maintaining and/or amplifying their feminine gender expression.

Nearly every participant expressed concerns about being victimized by staff or inmates due to their feminine identity or expression. Alicia, a Latina participant who had been incarcerated once, highlighted the fear of being victimized and the consequence of standing up for herself, noting:

I feel like living in fear in there, not knowing if someone's going to try to kill you for standing up for yourself is 10 times harder than being in general society. Like people might discriminate against you in the general society, but being in there it's like you literally have to stand up for yourself and do whatever you have to do to survive.

For some participants, a desire to survive the prison experience relatively unscathed motivated them to conceal their transgender identity and/or feminine gender expression for

the duration of their sentence. Tina, a White woman with a more fluid gender expression, described her rationale for not publicly identifying as a transgender woman while incarcerated, explaining: “I did not identify as transgender in jail. Because that would be dangerous and it could cause conflicts that I just preferred not to have. What they don't know won't hurt me.” Like several other participants, Tina had been incarcerated many times and had witnessed inmates being victimized for displaying any signs of femininity – experiences that motivated her to conceal her transgender identity. Some participants also described being motivated to conceal their gender when first entering jail or prison as they did not want to attract “unnecessary attention” and increase their risk of victimization. The ability to conceal, however, was only available to participants who were not visibly feminine (e.g., did not have breasts) and could pass as male.

While some participants never openly identified as transgender, others chose to downplay their gender expression in an effort to avoid mistreatment. One strategy some participants used to conceal their femininity and conform to male gender norms was going off hormone therapy, as hormone therapy not only feminizes the body, but taking hormones alerts staff and others to one's transgender status. For example, Evy, a visibly feminine Latina participant, described going off hormones to prevent stigma noting:

I stopped taking the estrogen... I never brought the estrogen back up again. Because I felt if I brought it up maybe I would be looked at as a certain individual or maybe even a risk factor, because, you know, differences and stuff like that. People look at things and they categorize you as, 'oh, that's a risk, you know?'

Evy's quote suggests that femininity is viewed as a problem or “risk” that correctional institutions must manage – a label that transgender women could avoid by pausing hormone therapy and concealing their transgender identity.

While concealing a transgender identity and/or feminine gender expression could be beneficial in terms of avoiding mistreatment, some participants were unable to conceal their femininity, for example if they had breasts, and others were unwilling to conceal their gender identity or feminine gender expression regardless of the consequences. For example, Taylor described her attitudes towards another transgender woman who concealed her transgender history in prison due to safety concerns noting: “There was one girl who ‘turned boy’ for a while inside the prison. She turned back to boy. She felt threatened. Afraid, like I did. But I just wasn't willing to give up my femininity just for the fear.” Taylor's quote illustrates how her desire to maintain her authentic self led her to actively resist the gender binary despite the fear of being victimized. Like several other participants who resisted the gender binary, Taylor had been living as woman for many years before being incarcerated and thus felt incapable of living as a man, despite the potential health benefit of concealment. Further, some participants, particularly those who had been incarcerated before or who knew other inmates from the “streets,” felt they had the social capital and mental and physical toughness to manage the threat of victimization that came with being a transgender woman in a male facility.

Several participants described their resistance against the gender binary, finding ways to express their feminine gender despite the threat of mistreatment by providers, custody staff,

and inmates. Indeed, some participants challenged the gender binary in small ways, such as Abby a White participant who had been incarcerated for 2 months, who noted: “Oh, I kept myself clean-shaven the entire time, and I still showed that walk.” Other participants expressed their femininity in more obvious ways and described the ways in which maintaining their feminine gender expression benefitted their mental health. For example, Evy, a Latina participant who had been incarcerated for about a year said: “I would draw on eyebrows...They had one of these good pens. A State pen. And I used it. I probably could have took my eye out, but I used it, and it got me through.”

Another way participants challenged the gender binary was by seeking out and often fighting to receive hormone therapy regardless of the barriers or potential consequences they faced. For example, Sierra highlighted how the bureaucratic jail system and lack of urgency on the part of providers created delays in accessing hormone therapy during her last sentence, which was just over 3 years: “It took me about a few months to get my hormones in jail. My lawyer had to fight for them. I had to fight for everything I got.” Like Sierra, many participants described fighting to access medically necessary hormones. For these participants, the very act of accessing hormone therapy in a male institution served to challenge institutional efforts to defeminize them and gave them a small, but meaningful, sense of empowerment that helped them cope with the challenges of being incarcerated in a sex-segregated institution.

“The Healthcare Systems in the Prisons Definitely Need to be Looked At” - Transgender Women’s Policy and Training Recommendations

Many participants highlighted specific concerns about the inadequate, and often biased, care they received while incarcerated, and noted specific ways that correctional healthcare could be improved. For example, Brandy noted: “I just feel like the healthcare systems in the prisons definitely need to be looked at.” When asked what could be done to improve healthcare for incarcerated transgender women, several participants, including Brandy and Evy cited the need for better access to care.

I think hormones and services should be available for everyone at request.... They have to offer some type of services because people need different kinds of help.

Why would you stop your transition due to being incarcerated? If something is going on that needs medication it’s not safe to stop and keep on going...It should be a little more easier [to get hormones], because there is silent discrimination and harassment going on with it.

Another primary way that participants believed that healthcare access, and the overall treatment of incarcerated transgender people, could be improved is through training providers and other correctional staff. Sierra and Nadia, both Black women who had each served more than 2 years in prison, highlighted the need for cultural competency training, noting:

Education. You know what I’m saying? Just a lot of education. A lot of training that we are not bad people, we’re just trying to be ourselves.

Teach cultural sensitivity, don't gawk at people, don't make people feel different... We didn't ask you to draw blood but you're still working with the public, and you owe the public...it's a disservice for you to allow certain things, like calling someone a fucking freak. There needs to be more cultural sensitivity in jails. It needs to start with staff.

Transgender women described exposure to transgender people and their stories as an essential component of educational efforts to improve the cultural competency of providers. For example, Rosa, a Latina participant, and Chrissy, a White participant, noted:

Educate them when it comes to anything that they believe that they haven't seen, I think educate them with that. Why not give them a chance to know there's gay people out there, trans people, there's even [trans men]. Let them know so when weird things come in they won't even think it's weird, they'll be like 'oh, oh okay'. You know?

Give them sensitivity training where they can actually get to know peoples' stories. It's about exposure and more or less understanding. Once we get clear of that ignorance, [transphobia] is not something that will be tolerated.

Rosa and Chrissy highlight how exposure to the experiences of transgender people can help normalize transgender individuals and lead to better treatment by providers and other staff.

Finally, several participants cited the necessity for correctional institutions to become better prepared to meet the needs of the transgender inmate population. The urgent need for transgender cultural and medical competency in jails and prisons was best noted by Cali, a 28 year-old participant who had been in and out of county jails, noted:

They need to be more sensitive and understand transgender [health]. They need to go through that type of training because being transgender is common now. This is not, 'you see one person one year, and two more people come out the next year.' It's a whole nation of us now, so at the end of the day people need to start opening up, to want to learn a little bit more about transsexuals, point blank. Period.

DISCUSSION

Findings from this qualitative study of formerly incarcerated transgender women illustrate how institutional policies and a correctional culture of transphobia serve to create and reinforce a gender binary environment where one's gender identity and expression are required to align with one's assigned sex at birth. Participant narratives found that transphobic attitudes and policies were regularly enacted at the institutional-level, shaping transgender women's access to quality, gender-affirmative care. The frequent mistreatment by biased or untrained providers and other staff ultimately shaped the behaviors of incarcerated transgender women, leading some to discontinue their hormone use and/or conceal their transgender identity as a form of stigma management (White Hughto et al., 2015, Goffman, 1963). Despite the risk of mistreatment and the challenges posed by fighting back against a disempowering institution, a subset of transgender women in this study actively challenged institutional and interpersonal efforts to maintain the gender binary.

Findings from this study highlight the need for policy and training interventions to improve the cultural and clinical competency of correctional healthcare providers and access to quality, gender-affirmative care for incarcerated transgender women.

Structured according to sex, and more specifically genitalia, jails and prisons are ripe for the production and reification of transgender stigma. At the institutional-level, transgender women reported the enforcement of policies that required them to conform to masculine gender norms by removing hairstyles, clothes, and accessories perceived to be feminine – a finding that aligns with 2014 survey results in which the majority of 221 transgender inmates sampled were not allowed to access underwear and cosmetics that match their gender identity (Lydon et al., 2015). Healthcare policies further restricted the feminine gender expression of some transgender women who were unable to provide documentation of their prior hormone use. Extending 2009 survey research conducted with transgender and gender variant inmates in Pennsylvania (Emmer et al., 2011) several participants reported taking street hormones outside of a physicians' care prior to incarceration and were unable to prove the medical necessity of hormones according to the standards of the facilities where they were detained. Participants who were marginally housed prior to incarceration also faced challenges documenting their prior hormone use, despite having been prescribed hormones by a licensed physician. Participants described the toll that barriers to hormone access had on their wellbeing, namely the stress caused by challenging the institution in which one held little power and their forced conformity to male gender norms. Prior research demonstrates an association between an inability to access hormones and a range of physical and mental health harms including irregular blood pressure, hair loss, anxiety, panic attacks, depression, auto-castration, and death by suicide in samples of incarcerated and non-incarcerated individuals (Summers and Onate, 2014, Brown, 2010, Huft, 2008, Spicer, 2010). Findings from this study suggest that despite the negative health consequences of restricting transgender people's access to hormones, and activist efforts to improve access to care for transgender inmates (e.g., Sevelius and Jenness, 2017), restrictive hormone policies persist in many U.S. jails and prisons and/or supportive policies are not being routinely enforced. Findings warrant mixed-methods research to document current healthcare policies involving transgender inmates and explore the extent to which policies are enforced through interviews with correctional administrators and providers.

Restrictive policies and a culture of transphobia guided the delivery of care and shaped the healthcare experiences of transgender women while incarcerated. Participants reported biased interactions with providers that mirrored the biased encounters they had with custody staff. Findings from this research extends prior survey research documenting the prevalence of disrespect by healthcare staff in a sample of incarcerated LGBTQ inmates (Lydon et al., 2015), by examining the varied ways in which transgender women were mistreated by correctional providers. When asked to describe specific incidents of provider mistreatment, participants reported frequent attempts by medical staff to belittle and defeminize them by using male pronouns. Extending prior survey research in which the majority of transgender inmates reported receiving inadequate care (Emmer et al., 2011), the present study contextualized the care experiences of incarcerated transgender women, as participants reported long delays accessing transition-related care, an ambivalence on the part of providers regarding the importance of accessing hormone therapy, and the prioritization of

other medications deemed to be more medically necessary than hormones (e.g., mood stabilizing medications, HIV medications) – a finding unique to this research. Providers' desire to prevent gender-based violence by limiting the feminine gender expression of transgender women was also cited as one rationale for withholding hormones – an act which serves as a form of symbolic violence (Valentine, 2007), with dire health implications (Summers and Onate, 2014, Brown, 2010, Huft, 2008, Spicer, 2010). Given that lack of access to hormones can result in a variety of negative health consequences for transgender individuals, it is important that providers and administrators in correctional settings recognize hormones as being as important as any other medical treatment and ensure equitable and appropriate access to hormones for transgender people under their care.

While some participants attributed inadequate care to bias, other participants attributed provider mistreatment to lack of exposure to transgender individuals and limited knowledge on how to appropriately meet their healthcare needs. As a result of limited provider knowledge, some transgender women reported feeling as though they were a phenomenon to be studied. Research suggests that the prison environment is a de-humanizing experience for all inmates, and so it's possible that the care participants received was not uniquely different from the care other inmates received (Toch and Gibbs, 1992, Vasiljevic and Viki, 2013, Kelso, 2014). However, transgender people outside of prison report similar experience of being “studied” by inexperienced providers (Poteat et al., 2013, Lurie, 2005, Snelgrove et al., 2012). Moreover, transgender people are inherently “othered” in the sex-segregated environment of correctional settings, thus the experience of being misgendered and further dehumanized may be particularly triggering for transgender people in carceral settings. Finally, it should be noted that while participants overwhelmingly described negative encounters with correctional providers, a few participants described satisfactory and even supportive interactions with primary care providers and counselors. These findings suggest that even in the oppressive environment of correctional settings, quality care is possible. Future qualitative research should seek to identify best practices for transgender care among supportive providers and leverage these findings in cultural and clinical competency trainings for healthcare staff working in jails and prisons.

Despite perceived and experienced stigma across the correctional environment, many participants were highly resilient, utilizing various strategies to protect their physical and emotional wellbeing. Consistent with prior research in non-correctional settings (Mizock and Mueser, 2014), some transgender women choose to conceal or minimize their femininity, which served as a form of resilience against the harms of victimization. Still, many participants were unwilling to conceal their gender identity or expression despite the threat of victimization - acts which demonstrated their resilience against the harmful mental health costs of being forced into the male gender binary. Participants' decision to conceal or disclose their transgender experience while incarcerated largely hinged on their ability to “pass” as male as well as the extent to which they anticipated victimization – perceptions that varied according to their incarceration history, relationships with other inmates, and perceived ability to prevent victimization. For those participants who challenged the gender binary through their clothes, mannerisms, or unwavering fight to access hormones, legal and media reports dating back to the 1990s highlight similar instances of transgender inmates who fought the system in order to live authentically while incarcerated (see legal reviews by

Arkles, 2012, Smith, 2006, Jenness and Smyth, 2011). While some transgender inmates have been successful in overcoming institutional barriers to care, due to the little power held by detainees, particularly those who are highly marginalized, transgender inmates' efforts to challenge institutional policies and practices could be met with further mistreatment. Consequently, interventions that seek to leverage the strengths and resiliencies of incarcerated transgender people in challenging institutional policies and practices should consider the risks and benefits of such efforts before being implemented.

Recommendations to Resist the Gender Binary: Needed Interventions

Drawing on participant interviews, and prior research and advocacy work with incarcerated transgender people (e.g. Sevelius & Jenness, 2017; Lydon et al., 2005), intervention strategies to resist the gender binary at each level are listed in the bottom portion of Figure 1, under each concentric circle's title. At the individual-level, transgender inmates should be informed of their rights and provided with guidance on how to obtain legal counsel when their rights are violated, however, individual efforts to challenge the gender binary, such as those described above, could threaten the safety of transgender inmates and therefore are not recommended as primary intervention approaches. Structural and interpersonal interventions that target the source of transphobia in correctional settings (e.g., policies and staff) should be developed and implemented to improve access to gender-affirmative care for incarcerated transgender people.

As noted by the formerly incarcerated transgender women in this study, transgender individuals have limited access to hormones in U.S. jails and prisons. According to a 2009 study (Brown and McDuffie, 2009), the vast majority of jurisdictions have policies that allow transgender individuals to continue hormone therapy provided that they are able to provide sufficient documentation (i.e., medical records) proving that they were prescribed hormones by a physician prior to incarceration. Correctional healthcare providers report that the policies requiring documentation of prior use of hormones are in place to reduce healthcare expenditures and prevent inmates from exploiting their access to free healthcare by acquiring medications that were not deemed medically necessary prior to incarceration (Clark and Hughto White, 2016). However, hormone therapy is a low cost intervention (e.g., generic estrogen pills cost less than \$15 per month (Consumer Reports, 2008)) and therefore unlikely to place a large burden on correctional budgets. Given that correctional providers are able to diagnose and treat patients suffering from acute physical and mental health conditions (e.g. HIV/AIDS, depression) (Ax et al., 2007, Baillargeon et al., 2008), current policies that restrict hormone use in the absence of proper documentation represent structural forms of transgender stigma and must be changed. Policy changes that eliminate prior documentation of hormone use can ensure the continuity of medical gender affirmation for incarcerated transgender individuals with potentially powerful mental health implications, including reductions in gender dysphoria and depression and improved quality of life (White Hughto and Reisner, 2016, Murad et al., 2010).

In the absence of proper documentation of prior hormone use, correctional institutions should follow the same policies and practices they utilize to manage patients with other acute physical and mental health conditions; that is, diagnose and treat transgender patients

in need of care (Ax et al., 2007, Baillargeon et al., 2008). For patients who are gender dysphoric, providers can utilize the criteria in version 5 of the Diagnostic and Statistical Manual to diagnose patients (APA, 2013) and provide appropriate treatment (e.g., mental health counseling, hormone therapy) (Coleman et al., 2012). Since a mental health diagnosis should not be required for transgender people to access medically necessary care, regardless of incarceration status, primary care providers can follow the informed consent model of care, by informing transgender patients of the risks and benefits of hormone therapy, and prescribe hormones following patient consent (Cavanaugh et al., 2016). If restricted by institutional policies requiring verification of prior hormone use, providers could test for elevated-levels of cross-sex hormones in the blood (Hembree et al., 2009). For transgender individuals who were taking low or irregular doses of hormones or hormones that cannot be detected in the blood (e.g., conjugated or synthetic estrogens) (Hembree et al., 2009), providers could conduct a physical exam to detect the effects of hormones, such as assessing whether breast tissue is present in transgender women. While physical exams may not conclusively confirm prior hormone use, particularly among those who had initiated hormone therapy shortly before being incarcerated, such strategies would likely improve access to hormone therapies for patients with a longer history of taking hormones. Together, these strategies provide correctional providers with a set of tools to navigate restrictive hormone policies and play an active role in resisting the gender binary and ensuring transgender patients have access to medically necessary therapies while incarcerated.

When asked about what could be done to improve healthcare for incarcerated transgender women, the majority of participants cited the need for transgender cultural and clinical competency training for providers. Educational efforts to increase community healthcare providers' transgender cultural competency (e.g.: "Transgender 101" trainings) have been successful in improving provider awareness and understanding of transgender patients by exposing them to the healthcare barriers that transgender people encounter (Hanssmann et al., 2008). Interventions to improve providers' transgender medical knowledge have also demonstrated success, as a lecture covering the durability of gender identity and hormonal treatment regimens significantly increased physician-residents' knowledge and willingness to provide hormonal therapy to transgender patients (Thomas and Safer, 2015). While education is important, the current study, along with prior research with community providers, implicates lack of exposure to transgender people as a barrier to providers' comfort and ability to care for transgender patients (Lurie, 2005, Poteat et al., 2013). Inter-group contact is effective in reducing prejudice among diverse populations (Pettigrew and Tropp, 2006). Intervention research with correctional healthcare providers suggests that transgender cultural and clinical competence trainings, which incorporate exposure to transgender people and their stories, and account for the unique structural barriers to healthcare in jails and prisons, can help increase providers' ability to care for transgender patients; pilot testing of this intervention is currently underway.

Limitations

The results of this study should be interpreted in light of several limitations. The present study examined the experiences of formerly incarcerated transgender women, the majority of whom had been incarcerated in male facilities in one or more New England state.

Therefore, these findings may not transfer to other settings or populations (e.g., transgender men in male or female facilities, transgender women in female facilities, or transgender people in non-U.S. contexts). Due to many participants strong desire to affirm their gender, it is possible that participants more readily recalled negative healthcare experiences than positive encounters, thus the data may be subjects to recall bias. Nonetheless, our findings extend prior quantitative research documenting structural and interpersonal barriers to care among incarcerated transgender individuals (e.g., Brown, 2009; Lydon, 2015). Additionally, the findings reported here only represent the perspective of transgender women who sought healthcare while incarcerated, and do not account for the perspectives of providers in these settings. Providers may face unique barriers to providing gender-affirmative care that are not known to transgender inmates and thus not documented here. Furthermore, the study did not systematically examine the attitudes and behaviors of providers according to specialty. Future qualitative research exploring correctional providers' perspectives and experiences caring for transgender patients, and exploring differences by provider training, would likely enhance care for incarcerated transgender women.

Conclusion

In sum, the present study suggests that transgender women face immense challenges accessing medically necessary care in correctional settings. Structural factors such as restrictive hormone policies and an institutional culture of transphobia limit hormone access and the feminine gender expression of incarcerated transgender women. Interpersonal factors, such as biased and uninformed providers, frequently limited access to general and transition-related care, but also demoralized many of the study participants and further contributed to their poor quality of life while incarcerated. Participant narratives show that despite being confronted with interpersonal stigma and structural barriers to care, the transgender women in this study are resilient as they used a variety of strategies to resist and survive the prison environment. The findings presented here serve as a starting point for future exploration into the delivery of healthcare to incarcerated transgender individuals and ultimately educational and policy interventions to improve access to gender-affirmative care for incarcerated transgender communities.

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Figure 1.
Transgender Women's Experiences Accessing Healthcare in U.S. Jails and Prisons and
Recommendations to Resist the Gender Binary at Multiple Levels

Table 1

Demographics, healthcare utilization, and incarceration history characteristics in a sample formerly incarcerated transgender women (n=20).

DEMOGRAPHICS		
Age (in years)	Mean	SD
Range: 22 to 53	36.9	10.00
Age (categorical)	%	n
18–29	30.0	6
30–39	30.0	6
40–49	20.0	4
50+	20.0	4
Race/Ethnicity **		
White, non-Hispanic	30.0	6
Person of color ^a	70.0	14
White	45.0	9
Black	50.0	10
Hispanic/Latina	25.0	5
American Indian or Alaskan Native	10.0	2
Asian or Pacific Islander	5.0	1
Other race	25.0	5
Education		
Less than a high school degree	35.0	7
High school degree	40.0	8
Some college	25.0	5
Employment Status		
Student	5.0	1
Employed full time	5.0	1
Unemployed	90.0	18
Receiving SSI or Disability		
Yes	55.0	11
No	45.0	9
Income		
< \$6,000 a year	75.0	15
\$6,000 to \$11,999	15.0	3
\$12,000 to \$17,999	5.0	1
Don't know	5.0	1
HIV Status		
Positive	35.0	7
Negative	60.0	12
Don't know	5.0	1

DEMOGRAPHICS		
HEALTHCARE UTILIZATION OUTSIDE OF JAIL OR PRISON - LIFETIME		
Taken Hormones		
Yes	90.0	18
No	10.0	2
Age Started Hormones ^b	Mean	SD
n=17: Range (11–32)	22.0	6.2
Received Breast Enlargement/Augmentation Surgery	%	n
Yes	25.0	5
No	75.0	15
Received Sex Reassignment Surgery		
Yes	0.0	0
No	100.0	20
HEALTHCARE UTILIZATION IN JAIL OR PRISON – MOST RECENT INCARCERATION		
On Hormones Prior to Incarceration		
Yes	60.0	12
No	40.0	8
Obtained Hormone Therapy (n=12) ^c		
Yes	33.3	4
No	66.7	8
Physical Health Conditions for which Treatment was Sought		
HIV/AIDS	25.0	5
Diabetes	5.0	1
Insomnia	5.0	1
Cold	5.0	1
Skin infection	5.0	1
Urinary tract infection	5.0	1
Dental problem	10.0	2
Mental Health Conditions for which Treatment was Sought		
Anxiety	5.00	1
PTSD	5.00	1
Obtained Medical or Mental Healthcare (n=10) ^d		
Yes	70.0	7
No	30.0	3
INCARCERATION HISTORY - LIFETIME		
Number of Times Incarcerated	Mean	SD
Range: (1 to 20 times)	8.2	6.9
Longest Continuous Time Spent in Jail or Prison (in Years)		
Range (1 week to 30 years)	3.1	6.6

DEMOGRAPHICS		
Total Time Spent in Jail or Prison	%	<i>n</i>
0 to < 6 months	35.0	7
6 months to < a year	10.0	2
1 to < 2 years	10.0	2
2 to < 5 years	20.0	4
5 to < 10 years	5.0	1
10 or more years	20.0	4
Facilities Incarcerated **		
Youth or juvenile detention	5.0	1
County jail	80.0	16
State facility	15.0	3
Other (transportation jail)	5.0	1

*** Individual breakdown of racial/ethnic categories and categories for facilities where one was incarcerated are not mutually exclusive

^a Person of Color = Black, Hispanic/Latina, Asian, Native American, Multiracial, and Other race;

^b n=17, two participants never used hormones, and one did not know the age at which they started hormones;

^c n=12 is based on the number of participants who were on hormones prior to incarceration; and

^d n=10 is based on the 10 participants who sought medical care when last incarcerated