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HEALTHCARE ACCESS AND EXPERIENCES AMONG TRANSGENDER
UNIVERSITY STUDENTS

by

MICAH REISNER

A thesis submitted in partial fulfillment of the requirements
for Honors in the degree of Bachelor of Science
in the Department of Sociology
in the College of Sciences
at the University of Central Florida
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ABSTRACT

Background

As transgender identification rises in younger generations, it is imperative that colleges and universities account for the health and wellbeing of this growing subset of the student body. Previous research indicates that transgender populations experience unique barriers to accessing healthcare, including socioeconomic barriers and a lack of healthcare providers experienced in transgender medicine. These barriers contribute to low rates of healthcare utilization and significant health disparities in transgender populations.

Methods

A community health assessment of transgender and gender-nonconforming (TGNC) students at the University of Central Florida was conducted in order to assess: (1) students' access to and experiences with healthcare on-campus at Student Health Services and off-campus with other healthcare providers, (2) barriers affecting healthcare accessibility for TGNC students, and (3) the overall mental and physical health-related quality of life (HRQOL) of this population. These measures were assessed utilizing a 15-minute online survey administered via Qualtrics distributed during the Fall 2023 semester.

Results

TGNC students' HRQOL was found to be substantially poorer than the general population, particularly with regard to mental health. The most prominent socioeconomic barriers identified were related to financial dependence and insurance. Although students generally reported positive experiences with Student Health Services (SHS), respondents frequently reported lacking confidence or being unsure of their providers' knowledge of transgender medicine. Further, recent legislation in the state of Florida restricting the provision of transgender medicine represented an additional barrier to transition-related healthcare.

Conclusion

This research reveals significant structural barriers to transgender healthcare which require large-scale, policy-level changes to fully rectify. However, simple interventions such as a workshop, training, or lecture on transgender health for providers may serve to produce more inclusive healthcare experiences for transgender students in the meantime.

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INTRODUCTION

A 2021 Pew Research Center survey found that 5.1% of U.S. adults under the age of 30 are transgender or nonbinary, a figure over three times that of the general U.S. population (1.6%) (Jones, 2021). For the purposes of this research, the term “transgender” will be used to refer to any person whose gender identity or expression is different, at least part of the time, from their assigned sex at birth, including individuals identifying as men, women, a nonbinary gender, or gender-nonconforming (Grant et al., 2011). As transgender identification rises in younger generations, it is imperative that colleges and universities account for the health and wellbeing of this growing subset of the student body. Many universities offer student health services to this end; however, few programs have expanded to provide transgender-inclusive healthcare. By offering transgender-inclusive healthcare programs, universities can better support the academic and personal success of transgender students.

Over the past century, transgender medicine has emerged as an increasingly relevant, though contentious, topic in healthcare. Despite the recent rise in public and political interest in the subject of transgender medicine, there remains scarce research regarding the healthcare needs of transgender populations, and a further lack of data centered on the health of transgender university students. This study aims to contribute to the growing body of literature by investigating the current health status of transgender students and factors affecting the accessibility and efficacy of existing university health services in meeting the healthcare needs of this population. To this end, the investigator has conducted a community health assessment of transgender students at the University of Central Florida (UCF), a large urban public university in Orlando, Florida. This assessment examines students’ health-related quality of life (HRQOL) and its potential relation to any discriminatory experiences faced by transgender students at

UCF's Student Health Services as well as from off-campus healthcare providers. The goal of this research is to promote the health and wellness of the transgender community at UCF and solicit information regarding students' experiences with SHS, in hopes of promoting future growth and improvement in transgender healthcare at UCF SHS.

LITERATURE REVIEW

Transgender people experience incongruence between their self-identified gender and the sex they were assigned at birth (Winter et al., 2016). Some, though not necessarily all, transgender individuals experience gender dysphoria as a result of this incongruence. The fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM V) published in 2013 recognized and defined gender dysphoria as a condition in which a person's gender incongruence is so severe that it clinically impairs social or professional functioning (Dazy & Toze, 2018). Seeking to relieve this incongruence and/or dysphoria, transgender people often elect to pursue gender-affirming medical interventions, including but not limited to hormone replacement therapy (HRT) and gender-affirming surgical procedures. Further, transgender individuals frequently have specialized healthcare needs beyond transition-related care. For instance, transgender people may have unique mental health and sexual and reproductive healthcare (SRH) needs (Winter et al., 2016). Other obstacles may impede transgender populations from accessing healthcare unrelated to being transgender. Negative experiences with healthcare such as discrimination, ignorance, harassment, and abuse can deter transgender people from seeking necessary healthcare, likely contributing to disparities in mental and physical health in transgender populations (Seelman et al., 2017).

Foundations of Transgender Healthcare

The formal study of transgender health in western medicine began in the early 1900s with the work of pioneers such as Magnus Hirschfeld in Berlin and Harry Benjamin in New York (Shuster, 2021). With the establishment in 1978 of the World Professional Association for

Transgender Health (WPATH) – originally known as the Harry Benjamin International Gender Dysphoria Association – came the 1979 publication of the first standards of care (SOC) for the treatment of transgender individuals in (Shuster 2021). Since then, the field of transgender medicine has grown and progressed significantly; in 2022, the WPATH published the eighth version of its *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (Creager, 2022).

Contemporary Transgender Health

Although transgender medicine has progressed with incredible strides in the time since its foundations were laid, transgender populations continue to face significant disparities in both mental and physical health when compared to the general U.S. population (Valentine & Shipherd, 2018). Transgender populations face higher rates of mental illness, including depression (Reisner et al., 2016), anxiety (Borgogna et al., 2018), substance use (Day et al., 2017), self-harm (Lytle et al., 2016), and suicidality (Coulter et al., 2015). The 2015 United States Transgender Survey (USTS) found that 39% of survey respondents experienced severe psychological distress in the month prior to completing the survey, as compared with only 5% of the general population (USTS, 2015). 40% of respondents had attempted suicide in their lifetime, while 7% had attempted suicide in the previous year, as compared to 4.6% and 0.6% in the general population (USTS, 2015).

Although existing literature on transgender community health primarily addresses the mental health concerns of the population, research suggests that transgender populations are also at higher risk of chronic disease (King & Nazareth, 2006), HIV (Lindley et al., 2003), sexually

transmitted infections (STIs) (Park & Palefsky, 2010), and intimate partner violence (IPV) (Kulkin et al., 2007). The findings of the 2015 USTS further support the conclusions of Lindley et al. (2003), with transgender respondents reporting living with HIV at a rate (1.4%) nearly five times that of the general population (0.3%). Transgender women, in particular transgender women of color, are especially at risk for HIV; almost one in five (19%) of Black transgender women reported living with HIV (USTS, 2015).

The transgender community faces unique obstacles in mitigating these adverse health outcomes. These barriers fall into two interconnected categories impeding transgender healthcare accessibility: socioeconomic barriers and a lack of transgender-competent healthcare providers.

Barriers to Trans Healthcare Accessibility

Housing

Transgender populations are more susceptible to a number of socioeconomic challenges, including housing insecurity, employment discrimination, and poverty. Housing often poses a problem for transgender individuals who frequently face forms of housing discrimination such as being evicted from or denied a home due to being transgender (USTS, 2015). For instance, in Florida, the state which is the focus of this research, 29% of 2015 USTS respondents had experienced homelessness at some point in their lifetimes, while 14% had experienced homelessness in the year prior because of being transgender. Homelessness is particularly precarious for transgender populations, as they are less likely to access or utilize institutions such as homeless shelters which are frequently sex segregated and can be inhospitable to transgender people (USTS, 2015). Indeed, 32% of Floridian 2015 USTS respondents who had been homeless

at some point in the year prior avoided staying in a shelter out of fear of mistreatment because they are transgender. Homelessness is itself associated with poor health outcomes and a number of barriers to healthcare, including lacking the resources needed to access care, unmet human needs, stigma and discrimination, and structural and organizational barriers (Omerov et al., 2019).

Employment and Poverty

Transgender people face further forms of discrimination in employment and the workplace, including being fired, denied a promotion, or not being hired because they are transgender (USTS, 2015). Based on the Florida state report of the 2015 USTS, 14% of respondents who had ever been employed reported losing a job in their lifetime due to their gender identity or expression. This discrimination likely contributes to the elevated rates of unemployment and poverty in transgender populations. Florida is particularly affected by these disparities, potentially because of its at-will employment policy and lack of legal protection for transgender employees. 22% of Florida 2015 USTS respondents were unemployed, a rate more than four times that of the general U.S. transgender population (5%) and significantly more than the national unemployment rate (15%). Over one-quarter (27%) of Floridian respondents live in poverty, more than twice the rate of the general population (12%) (USTS, 2015). As a result, many transgender people cannot afford necessary healthcare. The National Transgender Discrimination Survey (NTDS) found that 48% of respondents had delayed accessing healthcare when sick or injured because they were unable to afford it (Grant et al., 2011).

Insurance

These statistics are particularly insidious given that more than half of the U.S. population relies on employment-based health insurance plans (Bunch & Keisler-Starkey, 2021). Discrimination in employment may contribute to the health disparities experienced by transgender populations as a result of diminished access to employment-based health insurance. This is reaffirmed by the findings of the 2014-2017 Behavioral Risk Factor Surveillance System (BRFSS), which found that transgender respondents were both less likely to report having insurance and more likely to report experiencing financial barriers to accessing healthcare (Baker, 2019).

Further data suggest that even transgender individuals with access to health insurance face discrimination in seeking coverage for their care. Nationally, one in four USTS respondents experienced a problem with their insurance within the previous year related to being transgender (2015). These issues are common for transgender people who have legally changed their gender marker seeking healthcare related to their natal anatomy. For instance, a transgender woman who is legally identified as “female” may be denied coverage for a prostate cancer screening. Similarly, transgender men are frequently denied coverage for gynecological care. Additionally, insurance coverage for transition-related care is inconsistent, with 55% of USTS respondents who requested coverage for transition-related surgery denied by their insurance, and 25% denied coverage for hormone replacement therapy (HRT) (USTS, 2015).

Competence, Confidence, and Comfort in Transgender Healthcare Provision

By far the greatest reported barrier to transgender individuals accessing healthcare is a lack of educated, informed, and experienced providers of transgender medicine (Korpaisarn &

Safer, 2018). Existing research points to the provider's competence, confidence, and comfort in practicing transgender medicine as primary factors influencing their quality of care. It is important to note that a provider's transgender-competency encompasses both their knowledge of the technical aspects of practicing transgender medicine as well as cultural competency.

Transgender Medical Education

A review of literature assessing transgender medical education in healthcare providers found a pervasive lack of education in transgender care across medical disciplines and levels of education, including medical students, primary care providers, endocrinologists, and other specialists involved in providing transgender healthcare (Korpaisarn & Safer, 2018). A study of 101 transgender women in New York City found access to a provider knowledgeable about transgender health to be the most frequently reported barrier to accessing care (32%). A qualitative assessment of 30 transgender people and 11 physicians (N=41) conducted in Winnipeg found an overwhelming lack of physician knowledge reported by both transgender people and physicians (McPhail et al., 2016). Transgender participants also noted that providers would at times deny care by referring transgender patients to the local health center specializing in transgender-related healthcare. One transgender man describes such an experience with a doctor, saying, "I think his exact words were: 'I have no issue with you being transgender or with the process. I'm just not familiar with it and I'd prefer that you did everything with Klinik, because I'm just not experienced,'" (McPhail et al., 2016, p. 73). Although these clinics can be an essential resource for many individuals seeking transgender-competent healthcare, large volumes of referrals from providers unwilling to treat transgender patients may overburden these health centers, leading to long waitlists for transgender patients seeking care. Participants also noted particular struggles regarding accessing specialty care, especially sexual and reproductive

healthcare. Given that comprehensive transgender healthcare can involve providers from a number of specialties (such as gynecologists, mental health providers, surgeons, and social workers), it is imperative that transgender health be a fundamental part of the education for all providers (Korpaisarn & Safer, 2018).

As a result of this lack of formal transgender health education, the burden of educating healthcare providers often falls to transgender people. One participant of the study commented, “I feel with going to healthcare practitioners, I have to educate people all the time. And I feel really resentful of that,” (McPhail et al., 2016, p. 73). Further research has found that transgender respondents who had to educate their providers about transgender people were four times more likely to delay necessary healthcare due to discrimination (Jaffee et al., 2016).

Additionally, physicians struggled with utilizing appropriate language and communication, indicating deficits in cultural competency (McPhail et al., 2016). Unfortunately, these failures of cultural fluency frequently result in transgender individuals facing both microaggressions and outright transphobia from even well-intentioned providers.

Despite these deficiencies in transgender health education, participants also indicated that though their doctors were uneducated in transgender health, the providers were willing to ask questions and learn (McPhail et al., 2016). In addition, physicians participating in the study expressed anxiety regarding their lack of knowledge in transgender healthcare and concern for the quality of care they are capable of providing to transgender patients (McPhail et al., 2016). However, existing literature on transgender healthcare demonstrates that the treatment needs of transgender populations often closely reflect those of the general population and are at times unrelated to gender or transition (Sperber et al., 2005). This indicates that the extent of

transgender-specific knowledge necessary to provide high-quality transgender healthcare is minimal.

In fact, Korpaisarn & Safer's (2018) systematic review found a number of interventions which improved transgender medical education, including clinical rotations, online education, student presentations, patient panels, lectures, workshops, and small group sessions. Interventions as minimal as a single dedicated lecture on gender identity (Eriksson et al., 2016) or a 90-minute workshop (Kidd et al., 2016) significantly improved providers' transgender medical knowledge and cultural competency (Korpaisarn & Safer, 2018). Taken together, this suggests that though physicians tend to be under-educated in transgender medicine, many are interested and invested in becoming better informed. Additionally, it indicates that relatively short and inexpensive interventions are effective in improving transgender health education.

Provider Transphobia

Improving transgender medical education serves as an effective means of improving the overall quality of transgender healthcare, actionable through established forms of educational intervention such as lectures and workshops. Though beneficial, such interventions overlook another significant factor in addressing the quality of transgender health. Previous research establishes that provider transphobia, defined as anti-transgender discrimination that transgender people experience from their medical providers, acts as a significant barrier to the quality of transgender medicine which is substantially more difficult to address than education (Pulice-Farrow et al., 2021).

This concept is illustrated by the results of a survey of 223 primary care providers in the Midwestern United States. The study found that half of the providers surveyed had cared for

transgender patients, but the majority had received very little formal or informal education on transgender healthcare (Stroumsa et al., 2019). Notably, this study found that increased hours of education was *not* associated with improved knowledge; rather, the only factor in the model predicting knowledge was a negative association between transphobia and provider knowledge. This indicates that “...education alone that simply fills gaps in knowledge without addressing the systematically socialized transphobia of healthcare professionals... will not likely be effective,” (McPhail et al., 2016, p. 76).

Reduced Healthcare Utilization

Cumulatively, the above barriers to care faced by the transgender community lead to significant disparities in healthcare access and utilization. One-third of 2015 USTS respondents who had seen a healthcare provider in the past year reported at least one negative experience related to being transgender, including refusal of treatment, verbal harassment, physical or sexual assault, or having to educate a provider about transgender health. Though these negative experiences are potentially dangerous and traumatic themselves, they also discourage transgender people from seeking and utilizing healthcare. The National Transgender Discrimination Survey (NTDS) found that respondents had postponed medical care when they were sick or injured due to discrimination (28%) and inability to afford it (48%) (Grant et al., 2011). Transgender individuals also reported denial of equal treatment in doctors’ offices and hospitals, emergency rooms, and mental health clinics. 19% of respondents had been refused treatment altogether by a doctor or other healthcare provider due to their gender identity or

expression. Grant et al. (2011) also found that transgender women and people of color, especially American Indians, were particularly likely to be refused care.

These results are reaffirmed by the findings for Florida participants in the 2015 USTS, which found that within the previous year, 25% of Floridian respondents did not see a doctor when necessary due to fears of being mistreated due to being transgender, and 40% did not see a doctor because they could not afford to. Additionally, those who do seek professional care risk providers denying their gender, even going so far as to attempt to alter, end, or “cure” their transgender identification, with 13% of 2015 USTS respondents reporting such an experience. In addition to the trauma inflicted on transgender people through these incidents, these negative experiences pose a danger to the transgender community as a whole. Research suggests that previous negative experiences with healthcare providers may prompt transgender people to avoid seeking care in the future due to fears of stigma (Shipherd et al., 2010). Such negative experiences have repercussions which may contribute significantly to the health disparities faced by transgender populations by discouraging transgender individuals from accessing healthcare in the future.

College Demographic

Though health disparities are pervasive throughout the transgender community, this research seeks to explore the particular experiences of the transgender subpopulation at UCF. There are a number of reasons why the college demographic is of particular interest with regard to transgender health. According to data from the NTDS, transgender students in higher education report high rates of abuse from students as well as teachers and staff, including

harassment and bullying (35%) and physical (5%) and sexual (3%) assault (Grant et al., 2011). 15% of NTDS student respondents reported having to leave school because of the severity of the harassment they experienced (Grant et al., 2011). Another 15% reported leaving school because of financial reasons related to their transition, while 11% reported that they lost or could not get financial assistance or scholarships due to being transgender (Grant et al., 2011). These findings clearly indicate that transgender populations experience marginalization within the student body, demonstrating the need for academic institutions to further support the health and wellbeing of this community.

Although there is a dearth of research focusing particularly on transgender college students, existing research suggests that students in general are subject to many of the same health disparities indicated by surveys of the general transgender population. A secondary data analysis of undergraduate and graduate respondents to the Fall 2013 American College Health Association – National College Health Assessment found that compared to their cisgender peers, transgender students reported more mental health diagnoses, trauma, and suicidality; experienced more violence and less safety; reported more sex partners and higher rates of sexually transmitted infections (STIs); faced higher rates of substance abuse and binge drinking with less harm reduction behavior; and experienced more barriers to academic success (Messman & Leslie, 2019). These data supports the hypothesis that transgender students face poorer health-related quality of life than cisgender students and further indicates the need for colleges and universities to improve the quality of campus transgender healthcare provision.

Theoretical Framework

Intersectionality

The elevated rates of poverty and homelessness in transgender populations provides an example of the utility of intersectional perspectives when considering transgender health. Coined by sociologist Kimberlé Williams Crenshaw (1989), intersectionality provides a conceptual framework based in understanding and acknowledging the compounding effects of holding multiple marginalized identities. Crenshaw describes intersectionality using the metaphor of road intersections. She conceives of axes of power such as race, class, and gender as streets along which dynamics of oppression travel. Individuals who are disadvantaged along multiple axes of power face the dangers of traversing a busy intersection of multiple streets, rather than a single road.

With this framework in mind, it is important to recognize the ways in which intersecting avenues of marginalization affect healthcare accessibility, utilization, and outcomes in transgender populations. Previous research suggests that people of color are more likely to perceive healthcare discrimination than their white counterparts (Casagrande et al., 2007). Based on the principles of intersectionality one would expect that transgender people of color would likely experience healthcare discrimination to a more severe degree than not only white cisgender individuals, but also cisgender people of color and transgender white people. Indeed, this is supported by findings by Kattari et al. (2015) which indicate that transgender people of color experience higher levels of anti-transgender discrimination in healthcare settings than their white transgender counterparts. Additional research suggests that multiple racial identities also have a compounding effect, with multiracial transgender men and women being more likely than

non-multiracial transgender people to delay medical care out of fears of discrimination (Jafee et al., 2016). Similarly, low socioeconomic status, poverty, and housing insecurity also serve as potential avenues of intersectionality.

Cisnormative Accountability Structures

Research from Lampe (2019) brings to light another important facet of the marginalization faced by transgender individuals in healthcare: cisnormative accountability structures. Lampe draws on West & Zimmerman's (1987) theory regarding "the accountability structure," the ways in which individuals expect others to act and hold others to social expectations, specifically expectations regarding what is and is not gender-appropriate (Heritage, 1984). Sociologists have demonstrated many ways in which people hold one another accountable to societal gender norms (West & Zimmerman, 1987). For instance, if someone expects women to uphold certain norms regarding femininity, then they will treat someone who does not adhere to these expectations as though that person is not a woman (Lampe, 2019). These expectations pervade all aspects of social life, including healthcare. In healthcare settings, providers assume patients' gender and then hold the patient accountable to the norms of that assumption (Heritage, 1984). Similarly, Lampe (2019) demonstrates that transgender individuals are subject to providers holding them accountable to cisnormative expectations. When transgender patients deviate from these expectations, providers enact gatekeeping measures to create barriers that can delay or prevent transgender people from accessing healthcare (Shuster, 2019). Such barriers may ultimately contribute to the significant health disparities faced by transgender populations (Johnson et al., 2018).

Minority Stress Theory

These disparities may also be understood through the conceptual framework of minority stress theory. Originally proposed by Meyer (2003) in relation to lesbian, gay, and bisexual (LGB) populations, the minority stress model suggests that the stigma, hostility, and discrimination faced by minoritized populations cause excess social stress and ultimately contribute to the poor mental health outcomes of these communities. Hendricks and Testa (2012) extend Meyer's model of minority stress to address concerns specific to transgender populations, particularly highlighting the role of internalized transphobia and adverse experiences related to gender identity resulting in expectations of further victimization. Research by Lefevor et al. (2019) reaffirms Hendricks and Testa's (2012) application of the minority stress model to transgender populations and further indicates that transgender individuals experienced higher levels of stress and worse mental health outcomes as compared with binary transgender individuals. In addition to mental health, it is possible that the minority stress model may also have connections to the general health disparities faced by the transgender populations. Research by Seelman et al. (2017) found that transgender individuals who delayed healthcare because of fear of discrimination had worse general health in the past month than those who had not delayed care or delayed care for other reasons.

METHODS

Setting

The University of Central Florida (UCF) is a large, urban public university in Orlando, Florida. It is one of the twelve institutions in the Florida State University System. In the Fall 2022 semester, it had a total enrollment of 68,442 students, making it the largest higher education institution in Florida by enrollment and one of the largest in the nation as a whole (UCF, 2023). The student body was made up of primarily undergraduate students, with over 58,000 undergraduates in attendance. UCF was also home to over 9,000 graduate students, 483 medical professional students, and 6,367 online students including both undergraduate and graduate students (UCF, 2023). 81% of students were age 25 and under, with an average age of 23.4 years (UCF, 2023). The average age for undergraduate students was 22.3 years, while for graduate students it was 30.8 years (UCF, 2023). 44.69% (N= 30,584) of the total university population were reported as male, while 55.31% (N=37,848) was reported as female and ten are reported as unspecified (UCF, 2023). It is unclear whether these values reflect the self-identified genders of students or their legal designations.

UCF is a relatively racially diverse institution and is designated a Hispanic Serving Institution (UCF, 2021). 44.7% of the total student body is reported as white (N=30,606), 28.2% as Hispanic/Latino (N=19,316), 9.7% as Black (N=6,673), 7.1% as Asian (N=4,884), 4.4% as multiracial (N=3,001), 1.1% as not specified (N=734), 0.1% as Native Hawaiian/Other Pacific Islander (N=81), and 0.1% as American Indian/Alaska Native (N=79) (UCF, 2023). 93% of the total student population has in-state Florida residency status (N=63,310), while the remaining 7% are considered out-of-state residents (N=5,082) (UCF, 2023).

UCF is also significant for its pre-existing resources for transgender students, including LGBTQ+ Student Support Services, a resource office for LGBTQ+ students and allies established in 2011 (UCF Civil Discourse and Engagement, n.d.). LGBTQ+ Services provides a number of resources for transgender students, including facilitating trainings and events, mapping gender-neutral restrooms on campus, and developing the “T-Guide,” a transgender and nonbinary resource guide to UCF (LGBTQ+ Services, 2019). The LGBTQ+ Caucus of UCF’s Student Government unites several LGBTQ+-focused Registered Student Organizations (RSOs) for further initiatives to improve LGBTQ+ students academic and collegiate experiences (UCF Student Government, n.d.).

UCF’s geographic setting in Orlando, Florida is notable due to the city’s reputation as among the most LGBTQ+-friendly cities in the nation (ParkSleepFly, 2021). However, recent legislative actions at the state level in Florida have significantly altered the landscape for Orlando’s queer – and particularly its transgender – residents. For instance, one ranking held Orlando as the third most LGBTQ+-friendly city in the United States in 2022, but that ranking fell to 34th in 2023 as a result of changes to healthcare access, equality, and affordability (Alvarez, 2023).

Legislation impacting transgender Floridians include: HB 1521, which prohibits individuals from using public restrooms which do not correspond with their assigned sex at birth at the risk of a second-degree misdemeanor; SB 266, which limits funding at state universities for programs related to diversity, equity, and inclusion; and SB 254, which both prohibits transgender youth from receiving transition-related care as well as placing significant new restrictions on transgender adults accessing transition-related care (Alvarez, 2023). Significantly,

the restrictions levied by SB 254 prevent the provision of transition-related care by nurse practitioners, who had previously been the providers of at least 80% of transition-related care in the state according to SPEKTRUM Health, an LGBTQ+ specialty clinic based in central Florida (Reed, 2023). As a result, many adult transgender Floridians may have permanently or temporarily lost access to transition-related care due to SB 254, and further restrictions and requirements implemented by the bill have created new barriers to adult Floridians regaining and maintaining access to transition-related care. The rapidly shifting landscape of transgender healthcare in Florida makes it especially pressing to examine the ways that these barriers to accessing care impact the health and well-being of the state's transgender population.

Sample

The data for this research were taken from a sample (N = 53) of University of Central Florida (UCF) students aged 18 or older enrolled in at least one course in the Fall 2023 semester who self-identify as transgender or gender-nonconforming (TGNC). For the purposes of this survey, TGNC was defined as “people whose gender identity or expression is different, at least part of the time, from the sex assigned to them at birth.” The goal of this study was to analyze the healthcare outcomes of students in this population in relation to their healthcare access and experiences. The total sample of eligible participants for this study was 53 students. These respondents were predominantly white undergraduate students with a mean age of 20.45 years (s = 3.23 years).

Data Collection

Data for this study were collected using a 15-minute survey administered online via Qualtrics, which was distributed to UCF students throughout October 2023. The survey was disseminated by posting flyers containing a QR code leading to the survey around campus, advertising through social media and listservs affiliated with LGBTQ+ campus clubs and organizations, and distributing the recruitment flyer in-person during classes and events on campus.

Measures

The survey measures for this study were based around the primary aim of assessing TGNC students' healthcare access and experiences, as well as their overall physical and mental health-related quality of life, which is defined as an individual's perceived physical and mental health over time (CDC, 2000). These measures also aimed to capture the prevalence of several barriers to transgender healthcare accessibility identified in previous research. This includes barriers related to socioeconomic factors such as housing, employment, financial insecurity, and insurance, as well as factors related to healthcare providers' knowledge, cultural fluency, and attitudes towards transgender patients. Because this study samples UCF students, the survey assessed respondents' healthcare experiences with both off-campus providers as well as on-campus at UCF's Student Health Services (SHS).

Health-related quality of life (HRQOL) was operationalized utilizing the Center of Disease Control's four-item Healthy Days assessment (HRQOL-4). This measure queries respondents regarding (1) self-reported health as well as, of the prior 30 days, the number of days

the participant has (2) felt physically unhealthy, (3) felt mentally unhealth, and (4) limited usual activities (Baker, 2019). This assessment is also utilized nationally in the Behavioral Risk Factor Surveillance System (BRFSS), which is administered by the CDC annually in every state (Baker, 2019). The BRFSS contains an optional module collecting data regarding sexual orientation and gender identity, allowing previous researchers to analyze the mean HRQOL of transgender respondents nationally (Baker, 2019). This provides further context into the results of this assessment in a nationally representative sample, offering a reference point for the analysis of HRQOL results from UCF students. Additionally, the Healthy Days assessment addresses both the mental and physical health of respondents, which is significant given the prevalence of health disparities in both regards in transgender populations.

Additional variables examined in this research are respondents' access to and experiences with healthcare at (1) Student Health Services and (2) off-campus healthcare providers. This was assessed using measures drawn from the 2015 USTS which address a number of potential experiences with healthcare, including having to teach providers about transgender healthcare, being refused healthcare, and being verbally, physically, or sexually assaulted in a healthcare setting.

This study also collected data on a number of other variables which might impact both respondents' healthcare access and experiences as well as their HRQOL. This includes socioeconomic barriers to transgender healthcare accessibility identified in previous research, which will be evaluated through the domains of financial security, housing, employment, and insurance. It also encompasses demographic data regarding age, race, gender, sexuality, assigned gender at birth, and relationship/marital status. Additional information of particular

interest in college student populations was collected, including whether students are at the undergraduate or graduate level, whether their courses are online or in-person, whether they are a first-generation college student, and whether they are engaged with any LGBTQ+ campus organizations.

Data were also collected regarding transition-related medical care utilized or desired by respondents, including counseling/therapy, hormone replacement therapy, puberty blockers, and gender-affirming surgery. Though these data were not directly utilized in the evaluation of this projects' research question, the information was collected in order to provide further insight into the healthcare needs of the TGNC student population at UCF.

Research Questions

1. At what rates do TGNC students utilize routine and transition-related healthcare?
2. What experiences do TGNC students have accessing healthcare on-campus and off-campus?
3. What barriers impact TGNC students' access to healthcare?
4. How does TGNC students' health-related quality of life compare to that of the general population?

Data Analysis

Due to the small sample size of this study, analysis of survey data was limited to descriptive statistics. Although the lack of correlational data presents a significant limitation in assessing the relationships between HRQOL and students' healthcare access and experiences,

these descriptive statistics suggest the prevalence of potential barriers to health equity facing transgender students.

RESULTS

Demographics

Out of 63 total responses to the online survey, 53 respondents met the eligibility criteria for inclusion (N = 53). The mean age of the sample was 20.45 years (s = 3.2 years), with participants ranging from 18 years to 34 years. The sample was disproportionately white (65.5%) and Asian (14.6%) compared to UCF's general population, while Hispanic (14.6%) and Black (1.8%) students were significantly underrepresented in the sample (Table 1).

Asked to choose only one of the following gender identity labels, 26% of respondents self-identified as transgender women (MTF), 22% as transgender men (FTM), 42% as non-binary/gender-nonconforming, and 8% as genderfluid (Table 2). When respondents selected all gender terms they identified with, the most common labels were: transgender (n = 32), trans (n = 32), nonbinary (n = 23), trans woman (MTF) (n = 14), gender-nonconforming or gender variant (n = 11), agender (n = 10), androgynous (n = 10), genderfluid (n = 10), genderqueer (n = 10), trans man (FTM) (n = 10), transexual (n = 5) (Table 3). 63.3% of respondents indicated being assigned female at birth (AFAB), while only 36.7% reported being assigned male at birth (AMAB).

The majority of respondents were never married (94.2%), with 53.9% being single, 21.2% partnered and cohabitating, and 25% partnered and living separately. When participants were asked to select all sexual orientation terms they identified with, the frequency of each label was: bisexual (n = 20), asexual (n = 12), lesbian (n = 9), queer (n = 9), demisexual (n = 8), pansexual (n = 7), gay (n = 2), heterosexual/straight (n = 2), same-gender loving (n = 2) (Table

4). Four respondents reported orientations not listed, including T4T (transgender for transgender), gynosexual, omnisexual, and aromantic.

Nearly all respondents were undergraduate students (96%), with only 2 graduate students participating in the survey. 20% of respondents were first-generation students, meaning that neither of the students' parent(s) or legal guardian(s) earned a bachelor's degree. Respondents predominantly enrolled in a mix of both online and in-person classes (72%), with 24% enrolling solely in in-person classes and only 4% participating exclusively in online courses. 62.3% of respondents were involved with at least one LGBTQ+ campus or student organization, although it is significant to note that this percentage may have been inflated due to the survey being distributed through social media pages, listservs, and events associated with LGBTQ+ campus organizations.

Health-Related Quality of Life (HRQOL)

On a five-point scale, with one being "poor" and five being "excellent," respondents' mean rating of their health in general was 3.07, corresponding to "good." 31.7% of the sample rated their health as "poor" or "fair," a significantly larger proportion than the 18.2% of cisgender respondents and 24.5% of transgender respondents of the 2014-2017 BRFSS identified in previous research by Baker (2019). This suggests that a larger percentage of UCF's TGNC population experiences below-average health than both the general cisgender and transgender populations of the United States.

Physical and mental health were assessed using the BRFSS "unhealthy days" summary index, which asks respondents for the total number of days over the course of the past 30 days

that their physical and/or mental health was not good (CDC, 2000). In terms of physical health, participants reported a mean of 8.6 unhealthy days (median = 3 days, $s = 9.9$ days), more than twice the average number reported on the BRFSS by Florida residents as a whole (3.0 days) (County Health Rankings, 2020). Concerningly, respondents indicated more than half of the past 30 days had been mentally unhealthy days, with a mean of 17 days in which their mental health was not good (median = 15 days, $s = 9.6$), more than four times the average number of mentally unhealthy days of Florida residents in general (County Health Rankings, 2020). Altogether, participants reported a total mean of 11.3 days (median = 10) during the previous 30 days during which poor physical or mental health kept them from doing their usual activities, including self-care, work, or recreation. For reference, data from the 2014-2017 BRFSS suggested a mean of 9.4 total mentally and physical unhealthy days among transgender respondents and 6.57 among cisgender respondents (Baker, 2019). This indicates that TGNC students at UCF experience more days of poor health than both the cisgender and transgender general populations, pointing to a particular need to address the health inequities and disparities affecting this population.

Socioeconomic Barriers

Financial Security

Socioeconomic barriers to transgender healthcare accessibility were assessed via the domains of financial security, housing, employment, and insurance. 75.5% of respondents indicated that they are “always” or “often” financially dependent on another individual(s) or organization(s) to afford basic life needs such as food, housing, or medical care. Only 4.1% of participants stated that they never require this type of assistance. Among those who required it, the most common

forms of financial assistance were through scholarships/financial aid (n = 36) and friends, family, or partner(s) (n = 35). 61.2% reported having difficulty affording enough food to eat at least some of the time, with 24.5% reporting it “rarely,” 28.6% “sometimes,” 4.1% “often,” and 4.1% “always.”

Housing

Many participants reported living in a residence owned or rented with others (38.3%), followed by living on-campus (27.7%), living with parents or family (19.2%), living in off-campus university housing (10.6%), living in a residence owned or rented without others (2%), and living with a partner, spouse, or other person who pays for housing (2%). No participants experienced homelessness in the past 3-6 months. All participants who reported living on-campus lived on the UCF Main Campus (n = 13). For those who lived off-campus, the most frequent means of commuting to campus were driving themselves (41.2%), UCF shuttle (29.4%), carpooling (14.7%), and walking or riding a bike, scooter, or skateboard (14.7%). Close to half of respondents (42.6%) did not pay for their own housing, while 21.3% paid for some of their housing, 14.9% paid for all of their own housing, 12.8% paid for most of their own housing, and 8.5% paid for about half of their own housing.

Employment and Insurance

Approximately half of respondents reported having jobs, with 42.6% having a part-time job (< 25 hours per week) and 6.4% having a full-time job (25+ hours per week). 25 hours per week was chosen as the cut-off for full-time employment as it represents the minimum hours to be considered eligible for employer-sponsored insurance benefits in Florida.

Most respondents (78.7%) indicated having some form of healthcare coverage in Florida, while 10.6% had no coverage and an additional 10.6% were unsure of their status. Those who were insured were overwhelmingly insured as dependents through a parent/guardian's insurance plan (86.5%). Of the participants who were insured through a parent/guardian, employer, spouse, or school, 61.8% reported that they had refrained from pursuing transition-related healthcare due to the source of their insurance. When these respondents were asked to elaborate on their experiences in a text box, most expressed concerns about their treatment being exposed to the primary insurance holder (often parents), leading to the student being outed, facing familial rejection, and other repercussions. Participants expressed, "My parents can see what it is used for, so I do not feel safe getting trans healthcare," and "I delayed pursuing medical transitioning, because it meant I had to come out to my parents." About half of write-in responses indicated that the respondent refrained from pursuing transition-related healthcare due to fears of being outed (n = 10) or parental disapproval (n = 10).

The respondents were asked a battery of insurance-related questions drawn from the 2015 USTS (Table 5). The findings show that some of the respondents experienced significant challenges. For example, of the seven who had requested their insurance company change their records to list their current name or gender, three respondents reported that their insurance company would not change their records, while four respondents reported that their company would. 26 respondents had sought coverage for hormone therapy for transition, with three reporting being denied. Seven participants sought coverage for surgery for transition, with three of these being denied. Out of eight respondents, three reported that their health insurance covers only some of the surgical care necessary for transition. Two respondents out of five had coverage for surgery for transition, but no surgeons in-network. Two respondents out of eight were denied

gender-specific healthcare, such as Pap smears, prostate exams, and mammograms because of being transgender. Finally, three participants out of 16 reported being denied coverage for other forms of routine healthcare due to being transgender.

Healthcare Access and Experiences

Utilization of Transition-Related Care

The survey assessed four forms of transition-related care: counseling/therapy, hormone replacement therapy (HRT), gender-affirming surgery, and puberty blockers (Table 6). Of these, counseling/therapy was the most accessible to participants, with 52.4% having had it, 35.7% having wanted it, 9.5% unsure if they want it, and only one respondent not wanting it (2.4%). This was followed by HRT, with 33.3% of respondents have had it, 38.1% have wanted it, 23.8% were not sure if they want it, and 4.8% did not want it. Regarding gender-affirming surgery, 9.5% of respondents have had it, 38.1% have wanted it, 38.1% were unsure, and 14.3% did not want it. The most inaccessible form of transition-related healthcare was puberty blockers, which no participant had, but 40.5% have wanted, with 14.3% unsure and 45.2% not wanting. Despite such a large portion of respondents reporting having wanted puberty blockers, it is likely that its inaccessibility is because transgender patients must start puberty blockers close to the onset of puberty, around the ages of 8 to 15 (Cleveland Clinic, 2022). This means that in order to utilize puberty blockers, transgender individuals must have parental support and consent to begin treatment from a young age.

Among those who have utilized transition-related healthcare, one in six respondents (16.7%) expressed that, in the past year, they had lost access to gender-affirming care which they

were previously receiving. Elaborating in a text box, all respondents (n = 6) indicated that they had lost access to their healthcare as a result of legislative changes in Florida, particularly SB 254, and related clinic closures. One participant wrote, “Ron DeSantis’s antitrans law in May [SB 254] made me unable to get a refill of HRT from Planned Parenthood. I was off HRT from May to September.” Another stated, “My endocrinologist had to close down his practice... because of the new laws and bills, I lost around 5 months of hormone therapy...” Participants who reported losing access to transition-related care indicated that the lapse lasted between two to five months. One participant expressed that they still have not regained access to HRT, stating, “Because of Ron DeSantis[’s] laws I can no longer get testosterone prescribed to me, even though I have been on it for over a year.”

Experiences with Healthcare Providers

88.4% of respondents indicated that they have seen a doctor or other healthcare provider within the past year. 44.2% of participants reported having a routine checkup within the past year, while an additional 34.9% reported a checkup within the past two years. 25.7% of respondents did not have a routine healthcare provider. Many of those with a routine healthcare provider lived within 10 miles of them (40%), while 32% lived between 10-25 miles from their provider, 12% lived 25-50 miles away, and 8% lived over 100 miles away. 8% saw their routine healthcare providers exclusively virtually. 23.1% of respondents indicated that their routine healthcare provider was associated with UCF Student Health Service (SHS). Many participants (42.9%) were not sure how much their routine healthcare provider knows about healthcare for transgender patients, and no participants reported their routine providers knowing “most” or “almost everything” about transgender healthcare.

27.8% of respondents indicated that they have the same provider for both routine and transition-related healthcare, while 58.7% of respondents did not have a transition-related healthcare provider (though this includes participants who may not have sought transition-related care). Participants traveled greater distances to see their transition-related providers, with only 11.8% of respondents living within 10 miles of their transition-related healthcare provider, 23.5% living between 10-25 miles, 17.6% living 25-50 miles away, and 11.8% living over 100 miles away. In contrast to routine healthcare, it was significantly more common for participants to see transition-related healthcare providers exclusively virtually (35.3%). None of the respondents reported that their transition-related healthcare providers were associated with UCF SHS, as SHS does not provide transition-related services (LGBTQ+ Services, 2019). Overall, respondents expressed moderate confidence in their transition-related providers' knowledge of transgender healthcare, with 13% stating their providers know "almost everything," 8.7% knowing "most things," 6.5% knowing "some things," and 4.4% knowing "almost nothing" about transgender healthcare (the remaining 66.7% consisted of 58.3% of respondents without transition-related healthcare providers and 8.3% who were unsure of their providers' knowledge).

In terms of healthcare access, 30.2% of respondents reported that there was a time in the past 12 months when they needed to see a doctor but could not because of the cost. Separately, 30.2% of participants expressed that they had refrained from seeking healthcare in the past 12 months because they thought they would be disrespected or mistreated as a transgender person. This suggests that both financial barriers and concerns of transphobia played equal roles in preventing participants from accessing necessary healthcare.

Experiences with healthcare providers were evaluated using a 10-item measure drawn from USTS, which queried respondents regarding whether or not they experienced each of the 10 items (Table 7). This measure was adapted for the purposes of this study to query respondents whether they experienced each item at SHS, at another healthcare provider, or not at all. Overall, SHS outperformed other healthcare providers regarding the frequency of negative experiences. Out of the 25 students who indicated ever using SHS, three negative experiences were reported as occurring at SHS in the past year: one respondent reported being denied transition-related healthcare, another indicated being denied routine healthcare, and a final participant stated that their doctor asked unnecessary/invasive questions about their transgender status which were not related to the reason for their visit. In contrast, five times as many negative experiences were reported at off-campus healthcare providers in the past year, for a total of 15 instances. These experiences included having to teach the provider about transgender health in order to receive appropriate care (n = 2), a provider refusing transition-related healthcare (n = 3), a provider refusing routine healthcare (n = 1), a provider asking unnecessary/invasive questions about their transgender status (n = 2), a provider using harsh or abusive language (n = 2), a provider being physically rough or abusive during treatment (n = 1), the respondent being verbally harassed in a healthcare setting (n = 2), the respondent being physically attacked in a healthcare setting (n = 1), and the participant experiencing unwanted sexual contact (including fondling, sexual assault, or rape) in a healthcare setting (n = 1).

Although respondents reported fewer negative experiences with SHS than with other healthcare providers, SHS nonetheless lagged behind other providers when respondents were queried as to whether their provider respected their TGNC identity. 14 participants reported this

experience at off-campus healthcare providers, whereas only 9 reported their TGNC identity being respected at SHS.

Experiences with Student Health Services

One of the goals of this research was to focus on students' experiences with SHS. In total, 56.1% of the sample reported using any services at UCF Student Health Services (SHS) ($n = 23$). Participants primarily reported “good” or “excellent” experiences with SHS staff including healthcare providers (78.3%), receptionists/billing staff (71.3%), and pharmacists (83.3%). The survey also evaluated the experiences of respondents with regards to certain facets of their treatment by SHS staff (including providers, pharmacists, receptions, and other employees) (Table 8). On a five-point scale, with one being “very poor” and five being “excellent,” SHS staff were rated in the following metrics: being knowledgeable about providing support to transgender and gender-nonconforming populations ($\bar{x} = 3.77$, $s = 1.12$), being open to discussing gender-related concerns ($\bar{x} = 3.73$, $s = 0.86$), being respectful about pronouns ($\bar{x} = 3.19$, $s = 1.33$), being respectful about patients’ names ($\bar{x} = 3.94$, $s = 0.97$), being respectful about patients’ preferred terms for their bodies ($\bar{x} = 3.14$, $s = 1.12$), and being respectful about how patients prefer to be physically examined/treated ($\bar{x} = 4.36$, $s = 0.88$). Overall, this suggests that TGNC students’ experiences with SHS staff have been relatively positive.

Despite these positive ratings, participants who elaborated on their experiences in an optional text box expressed inconsistency across their experiences at SHS, with one respondent noting, “They’re generally hit or miss. I’ve had relatively good experiences sometimes and then other times they’ll be entirely condescending and rude and treat me like I don’t know anything about me or my body or healthcare in general.” Other participants expressed that although they

were not mistreated, SHS staff did not seem comfortable interacting with transgender patients. Another participant stated, “I have not been directly mistreated, but most employees I have interacted with have seemed to not quite know what to do with me, how to address me (after being told my name and pronouns), and often just avoid gendering me completely. I would describe my overall experiences as uncomfortable.” Some respondents also suggested that they avoid potential mistreatment and discomfort by refraining from disclosing their transgender identity with SHS staff.

Finally, the survey examined barriers to utilizing transition-related healthcare services at SHS. 19.5% of respondents stated that they had refrained from using transition-related healthcare at SHS for any reason. Of those who had refrained from pursuing care at SHS, 33.3% did so due to concerns for mistreatment as a TGNC patient, 25% had concerns for health information privacy, 16.7% preferred other healthcare options, and 8.3% stated that SHS did not offer the services they were looking for.

DISCUSSION

Transgender Student Health

This study shows that the overall health of TGNC students at UCF lags significantly behind that of the general population, with survey respondents averaging substantially more unhealthy days than Florida residents in general (County Health Rankings, 2020). This was especially notable with regard to mentally unhealthy days – survey participants reported on average four times more mentally unhealthy days than Floridians as a whole.

Such findings could reflect the impact of Minority Stress Theory, which suggests that social stress sparked by the discrimination minoritized populations face ultimately contributes to poor mental health outcomes (Hendricks & Testa, 2012). That survey respondents report such a high number of mentally unhealthy days indicates that mental health resources currently available at UCF are inadequate to meet the needs of TGNC students. This is particularly notable given that more than half of respondents indicated they have previously utilized counseling/therapy, potentially suggesting that these interventions are insufficiently effective to overcome the mental health concerns facing this population.

There is also evidence to suggest a need to expand access to other forms of transition-related healthcare at Student Health Services. Over one-third of respondents reported desiring HRT, while one-third of respondents reported that they were already on it. However, UCF SHS currently does not employ an endocrinologist, so students are unable to receive HRT prescriptions without using off-campus healthcare providers. Although employing an endocrinologist with knowledge of transgender health needs would be the most direct way to serve these students, permitting students to complete routine bloodwork through the SHS lab

may be an additional potential measure to improve HRT accessibility for UCF students.

Transgender patients on HRT are often required to have their hormone levels evaluated through a blood draw approximately every three months (Planned Parenthood, n.d.). This may be particularly burdensome for students who have difficulty affording and obtaining transportation to off-campus labs. While UCF SHS currently does not fulfill third-party lab orders directly, adjusting this policy to accommodate for students needing bloodwork for HRT may significantly improve its accessibility to TGNC students at UCF.

Experiences at Student Health Services

Generally, respondents reported significantly lower frequencies of negative experiences at Student Health Services in comparison to other healthcare providers. This may, however, in part be due to the lack of transition-related healthcare provided by SHS. Although over half of the sample had utilized services at SHS, no respondents indicated having a transition-related healthcare provider associated with SHS. Participants primarily reported positive experiences with SHS staff, including healthcare providers, receptionists/billing personnel, and pharmacists. SHS staff were rated particularly highly in being respectful about patients' names and how they prefer to be physically examined/treated. However, SHS staff received lower ratings with regard to being respectful about patient's pronouns and preferred terms for their bodies. This reflects the struggles with utilizing appropriate language and communication also identified by McPhail et al. (2016). These findings suggest that improved language-based trainings for SHS staff might improve communication and enhance the comfort of staff who treat transgender patients, as well as the patients themselves.

Respondents reported that SHS staff were fairly knowledgeable about supporting TGNC populations and open to discussing gender-related concerns, suggesting that SHS staff are willing to learn and may be receptive to interventions targeting improved transgender cultural competency. Previous research suggests that minimal interventions, such as a single lecture or workshop, may be sufficient to significantly improve providers' transgender medical knowledge and cultural competency (Korpaisarn & Safer, 2018).

It is significant to note that some participants reported using selective disclosure strategies at SHS to circumvent any issues related to their transgender identification. "Selective disclosure" is defined by Sumerau & Mathers (2019) as "picking and choosing who knows [about one's transgender identity] based on safety and other concerns." One nonbinary lesbian respondent wrote, "It is easier for me to operate as a cis female lesbian in healthcare settings, since it is truthful about my sexuality and therefore any health concerns that could be related to it, and it avoids any conversations or issues that may arise from me saying that I am transgender/non-binary. I am able to omit that part of myself here because I am not currently seeking any kind of medical transition. I use my birth name and she/her pronouns in these settings. With this context, I have been treated very well by SHS staff." Another participant expressed, "I'm AMAB agender and use He/Him pronouns. SHS don't think of me as trans which is fine." This usage of selective disclosure strategies may be a means of circumventing cisnormative accountability structures, whereby providers enact gatekeeping measures to create barriers to healthcare access for transgender people who deviate from cisnormative expectations (Shuster, 2019). By electing not to disclose their transgender identity, these participants avoid any potential discriminatory experiences or barriers to healthcare related to their gender.

Socioeconomic Barriers

The most significant socioeconomic barriers to healthcare identified were related to insurance and financial dependence. Although most respondents indicated having healthcare coverage in Florida, the majority of these individuals were insured as dependents on a parent/guardian's insurance plan. This was found to be a common barrier to transition-related healthcare for TGNC students, who expressed concerns that using their parent or guardian's insurance would force them to come out or face repercussions from their families.

One respondent explained that the fear of losing insurance coverage through their parents led to a delay in their transition, stating, "I have previously refrained from purchasing HRT when my insurance plan was provided by my parents as they threatened to remove me from their plan if I started testosterone... I delayed by about two years based on their disapproval and the potential loss of insurance." Other participants shared similar experiences of being threatened with losing insurance coverage or financial support for seeking transition-related healthcare, with one respondent expressing, "Financial abuse limits my position."

These sentiments indicate that financial dependence contributes to insurance-related barriers to care, particularly when the student is insured as a dependent with a parent or legal guardian as the primary insurance holder. This is especially notable given that over three-quarters of participants were found to be "always" or "often" financially dependent on others to afford basic life needs, with friends, family, or partner(s) being one of the most common sources of financial support. This trend of financial dependence is reaffirmed by the findings that close to half of respondents did not pay at all for their own housing. Such financial dependence means

that TGNC students who are not out to or accepted by their families may not be able to access transition-related healthcare without risking being cut off from housing, insurance coverage, and other forms of financial assistance. Financial dependency, therefore – in particular being insured as a dependent – may be among the most common barriers to transition-related care in student populations. Even when considering routine healthcare, nearly one-third of respondents reported at least one instance within the past 12 months when they needed to see a doctor but could not because of the cost, further indicating the magnitude of financial barriers to healthcare access in this sample.

Provider Knowledge and Transphobia

The findings of this study also point to concerns about provider transphobia and a lack of confidence in providers' knowledge of transgender healthcare as additional barriers for TGNC students. Indeed, close to one-third of participants reported at least one instance within the past 12 months when they refrained from seeing a physician due to concerns over being disrespected or mistreated as a transgender, reflecting findings by Jaffee et al. (2016) suggesting that transgender people are more likely to delay healthcare due to discrimination.

For those that did seek healthcare, many expressed uncertainty and low levels of confidence in their physicians' knowledge of transgender healthcare for both routine and transition-related care. This was particularly pronounced in the case of routine healthcare providers, with no respondents reporting that their routine providers know more than “some things” about transgender healthcare. The majority of respondents did not have transition-related healthcare providers, with data indicating that this type of physician may have been especially

difficult to access; respondents reported traveling farther and using telehealth options more frequently for transition-related care. These findings support previous research by Korpaisarn & Safer (2018) which indicated that a lack of educated, informed, and experienced providers of transgender medicine presents one of the greatest barriers to transgender healthcare accessibility.

Legislative Barriers

The final barrier to transition-related care identified in this research was related to laws enacted in 2023 by the Florida legislature; in particular, SB 254, which placed further restrictions on access to transition-related care for transgender Floridians. Participants indicated that their access to treatments such as HRT was disrupted for up to five months due to SB 254 and related clinic closures. Less than a year from its introduction, the full impact of the changes brought about by SB 254 remains to be seen, but future research will likely find a similar dampening effect on access to transition-related care across Florida.

Limitations

The most significant limitation of this study was its sample size. With a sample of only 53 respondents of a population of over 68,000 students at UCF, statistical analysis for this study was limited to descriptive statistics. The researcher aims to expand the sample size in future studies, allowing for correlational relationships to be drawn between barriers to healthcare access experienced and respondents' health-related quality of life. Additionally, the sample was not representative of the general population of UCF, with significant underrepresentation of Hispanic and Black students. With a larger and more representative sample, future researchers may utilize

an intersectionality framework to assess correlations between holding multiple marginalized identities, healthcare accessibility, and health-related quality of life.

CONCLUSION

Transgender and gender-nonconforming (TGNC) students at the University of Central Florida demonstrate significant disparities in both physical and mental health-related quality of life. Students indicated a need for improved mental health services as well as expanded access to transition-related care such as HRT. While respondents were generally more positive about their experiences with UCF Student Health Services than with off-campus healthcare providers, data suggest a need for further interventions targeting communication and cultural fluency, particularly regarding the usage of correct pronouns and patients' preferred language for their bodies.

The major obstacles to healthcare accessibility for TGNC students identified in this study encompassed both socioeconomic barriers, such as financial dependence and insurance status, as well as a lack of healthcare providers fluent in transgender medicine. Participants indicated high rates of financial dependency on others – particularly family, friends, and partner(s) – in order to afford basic needs. This, coupled with frequently being insured as dependents of their parent(s) or guardian(s), led to respondents expressing an inability to access transition-related care without coming out to their families and facing potential rejection or reprisals, such as losing financial support or insurance coverage. In this way, financial dependency and insurance status present one of the most significant barriers to accessing transition-related healthcare in this sample.

Further barriers included concerns regarding discrimination and transphobia as well as a lack of accessible healthcare providers educated in transgender medicine. Many participants indicated uncertainty and a lack of confidence in their doctors' knowledge of transgender health, especially among providers of routine healthcare. Additionally, there is a need for improved

access to transition-related healthcare providers, as participants reported traveling farther and relying more heavily on telehealth for this type of care.

Significantly, legislation restricting the provision of transition-related care has arisen as a new obstacle to transgender healthcare accessibility. Following the passage of SB 254 in May of 2023, many Floridians experienced disruptions in their access to transition-related care due to new requirements and clinic closures. In this sample, one in six respondents experienced delays of up to five months. With less than six months between the passage of this legislation and collection of data for this study, future research may further illuminate the impact of these changes on transition-related care in Florida.

In the face of the rapidly shifting national landscape of transgender medicine, the need to combat health disparities and improve healthcare accessibility for transgender and gender-nonconforming populations is more urgent than ever. This research reveals significant structural barriers to transgender healthcare which require large-scale, policy-level changes to fully rectify. However, strategies may be employed to produce more inclusive healthcare experiences for transgender students in the meantime, including simple interventions such as a workshop, training or lecture on transgender health for SHS staff. Although these interventions would not fully resolve the structural issues facing this population, they may nonetheless serve to significantly improve healthcare accessibility, experiences, and outcomes for transgender and gender-nonconforming students at UCF (Korpaisarn & Safer, 2018).

APPENDIX: TABLES

Table 1

Race/Ethnicity

<i>Race</i>	<i>n</i>	<i>%</i>
Alaska Native	0	0.0%
Asian/Asian American	8	14.6%
Black/African American	1	1.8%
Indigenous American/American Indian	2	3.6%
Latino/a/Hispanic	8	14.6%
Middle Eastern/North African	0	0.0%
Native Hawaiian/Pacific Islander	0	0.0%
White/European American	36	65.5%
Total Respondents	53	-
Total Choices	55	-
<i>Note:</i> Respondents were asked to select all races they identify with. Two respondents indicated multiple races, resulting in a total of 55 choices selected by 53 total respondents.		

Table 2

Gender Category

<i>Gender Category</i>	<i>n</i>	<i>%</i>
Transgender Woman (MTF)	13	26%
Transgender Man (FTM)	11	22%
Nonbinary/Gender-nonconforming	21	42%
Genderfluid	4	8%
Not Listed Above	1	2%
Total Respondents	50	-
<i>Note:</i> Respondents were asked to select only one of the above terms which best described their current gender identity.		

Table 3*Gender Identity*

<i>Gender Identity</i>	<i>n</i>	<i>%</i>
Agender	10	5.5%
Androgynous	10	5.5%
Bigender	3	1.6%
Butch	3	1.6%
Crossdresser	0	0%
Drag performer (king/queen)	1	0.6%
Gender-nonconforming or gender variant	11	6%
Genderfluid	10	5.5%
Genderqueer	10	5.5%
Intersex	0	0%
Multi-gender	2	1.1%
Nonbinary	23	12.57%
Third gender	4	2.2%
Transgender	32	17.5%
Trans	32	17.5%
Trans man (FTM, female-to-male)	10	5.5%
Transsexual	5	2.7%
Trans woman (MTF, male-to-female)	14	7.7%
Two-Spirit	0	0%
Not Listed Above*	3	1.64%
Total Respondents	50	-
Total Choices	183	-

Note: Respondents were asked to select all gender identities they identify with. 43 respondents reported multiple sexual orientations, resulting in a total of 183 choices selected by 50 respondents.

*Other gender identities reported: trans masculine, demigender, autigender, boything

Table 4*Sexual Orientation*

<i>Sexual Orientation</i>	<i>n</i>	<i>%</i>
Asexual	12	16%
Bisexual	20	26.7%
Demisexual	8	10.7%
Gay	2	2.7%
Heterosexual/Straight	2	2.7%
Lesbian	9	12%
Pansexual	7	9.3%
Queer	9	12%
Same-Gender Loving	2	2.7%
Not Listed Above*	4	5.3%
Total Respondents	51	-
Total Choices	75	-

Note: Respondents were asked to select all sexual orientations they identify with. 13 respondents reported multiple sexual orientations, resulting in a total of 75 choices selected by 51 respondents.

*Other orientations reported: T4T, gynosexual, omnisexual, aromantic

Table 5*Health Insurance Experiences*

<i>Since I have been in college, my health insurance company...</i>	<i>Yes</i>		<i>No</i>		<i>I have not asked for this</i>		<i>Total</i>
	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>N</i>
...wouldn't change my records to list my current name or gender	6.4%	3	8.5%	4	85.1%	40	47
...denied me hormone therapy for transition	6.4%	3	27.7%	13	66%	31	47
...denied me surgery for transition	6.5%	3	8.7%	4	84.8%	39	46
...covers only some of the surgical care I need for my transition	10.9%	5	6.5%	3	82.6%	38	46
...covers surgery for transition, but has no surgery providers in their network	4.3%	2	10.6%	5	85.1%	40	47
...denied me gender-specific care (Pap smears, prostate exams, etc.) because I am trans	4.3%	2	12.8%	6	83%	39	47
...denied me other routine healthcare because I am trans	6.4%	3	27.7%	13	66%	31	47

Table 6*Gender-Affirming Care*

<i>Treatment</i>	<i>Have had it</i>		<i>Have wanted it</i>		<i>Not sure if I want this</i>		<i>Do not want this</i>		<i>Total</i>
	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>N</i>
Counseling/Therapy	52.4%	(22)	35.7%	(15)	9.5%	(4)	2.4%	(1)	42
Hormone Treatment/HRT	33.3%	(14)	38.1%	(16)	23.8%	(10)	4.8%	(2)	42
Puberty Blocking Hormones	0%	(0)	40.5%	(17)	14.3%	(6)	45.2%	(19)	42
Gender-Affirming Surgery	9.5%	(4)	38.1%	(16)	38.1%	(16)	14.3%	(6)	42

Table 7
Experiences with Providers

<i>In the past year...</i>	<i>No</i>		<i>Yes, at SHS</i>		<i>Yes, elsewhere</i>		<i>Total</i>
	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>N</i>
...my doctor respected my TGNC identity	20.7%	6	31%	9	48.3%	14	29
...I had to teach my provider about trans people to get appropriate care	90%	18	0%	0	10%	2	20
...a provider refused to give me trans-related healthcare	81%	17	4.8%	1	14.3%	3	21
...a provider refused to give me other healthcare	92%	23	4%	1	4%	1	25
...a provider asked me unnecessary or invasive questions about my trans status	87.5%	21	4.2%	1	8.3%	2	24
...a provider used harsh or abusive language when treating me	92.3%	24	0%	0	7.7%	2	26
...a provider was physically rough/abusive when treating me	96.3%	26	0%	0	3.7%	1	27
...I was verbally harassed in a healthcare setting	92.6%	25	0%	0	7.4%	2	27
...I was physically attacked during my visit in a healthcare setting	96.4%	27	0%	0	3.6%	1	28
...I experienced unwanted sexual contact in healthcare setting	96.4%	27	0%	0	3.6%	1	28

Table 8*SHS Staff*

<i>Experience</i>	\bar{x}	<i>s</i>
Knowledgeable about providing support to TGNC populations	3.77	1.12
Open to discussing gender-related concerns	3.73	0.86
Respectful about patients' pronouns	3.19	1.33
Respectful about patients' name	3.94	0.97
Respectful about patients' preferred terms for body	3.14	1.12
Respectful about how patient prefers to be physically examined/treated	4.36	0.88

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