Navigating Trans Care in Colorado

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Abstract

"Navigating Trans Care in Colorado" examines what safe and accessible gender-affirming care comprises and how trans folks access and navigate it in Colorado. Using Disability Studies and Queer Theory/Studies as frameworks attentive to Intersectionality, I analyze how transness is medically and socially pathologized and how medical care access is limited based on factors such as race, class, citizenship status, disability, and location. Additionally, I critique the Medical-Industrial Complex (MIC) as a site that, embedded in racism, eugenics, ableism, transphobia, white supremacy, and capitalism, renders public health into a profit enterprise rather than a fundamental human right. This research focuses on Colorado, as it is one of the few states that has established legal protections for trans individuals. Through research, networking, and interviews with trans folks with experience accessing gender-affirming care in Colorado, I compiled a Google Document of resources including gender-affirming doctors, sites to access informed-care hormone-replacement therapy (HRT), and non-Medical Industrial Complex community spaces.

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Introduction

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Transness has long been subjected to pathologization and medicalization, often viewed as a deviation from the norm and necessitating a "cure" or "treatment." This perspective has historically led to the exclusion of trans people from public health research and the marginalization of gender-affirming care within medical settings. At the heart of this lies the Medical Industrial Complex (MIC), a pervasive system deeply entrenched in capitalism, ableism, and various additional systems of oppression. The consequences of this systemic pathologization are profoundly evident, with trans people often facing discrimination and barriers to accessing essential healthcare services. In response to this historic pathologization, a movement of trans-depathologization has emerged — advocating for the recognition of transness and gender transition as a human right rather than a desire that is inherently deemed "ill." This shift challenges the prominent narrative within medical discourse, emphasizing the importance of gender-affirming care in supporting the well-being and survival of trans people. While changes have been made — notably in the Diagnostic and Statistical Manual of Mental Disorders (DSM) moving away from labeling transness as a mental disorder verbatim — significant challenges remain. Despite this progress, the classification of transness within the DSM perpetuates stigmatization.

Furthermore, the landscape for trans people is additionally complicated by the continual rise of anti-trans legislation across the United States, targeting basic rights such as access to healthcare, participation in sports, and the ability to use public facilities. This legislation not only threatens the physical safety and well-being of transgender individuals but also exacerbates existing barriers to accessing gender-affirming care. As legislative attacks escalate, the need for safe, trans-inclusive healthcare providers becomes increasingly urgent. Against this backdrop, this research aims to explore gender-affirming care in Colorado, a state emerging as a "safe haven" for transgender individuals seeking essential healthcare services. By investigating Colorado's legislative commitments and identifying trans-inclusive healthcare providers recommended by the transgender community, I seek to shed light on the challenges and opportunities for accessing gender-affirming care in the state. Drawing on Critical Disability Studies and Queer and Trans Theories, this research adopts an intersectional lens to examine the multifaceted experiences of transgender individuals navigating healthcare systems. Through community-based research and collaboration, this project sought to create a comprehensive resource that empowers transgender individuals to access affirming and inclusive healthcare.

Background

Transness has historically been pathologized and medicalized, viewed as a non-normative ‘condition’ that necessitates a ‘cure’ or a ‘fix.’ Inclusive providers are hard to come by due to the pathologization of transness in medical settings such as the Medical Industrial Complex (MIC), which categorizes transness as implicitly associated with illness and marked as a mental health concern rather than a pursuit of a more authentic self. The MIC broadly refers to the oppressive system of medicine under capitalism.[1] As described by Queer Korean Disability Justice activist Mia Mingus, the MIC is a system that encompasses and extends beyond doctors, nurses, clinics, and hospitals — it produces and perpetuates ableism, and is deeply embedded in eugenics, capitalism, colonization, slavery, immigration, war, prisons, and reproductive oppression.[2] This site includes pharmaceutical companies, public health policy and lawmakers, lobbyists, and private insurance companies; all of which turn public health into a for-profit enterprise rather than a necessary human right. Transness is often regarded, with the assistance of the Diagnostic and Statistical Manual of Mental Disorders (DSM), as an anomalous mental disorder, leading to the perceived need for treatment or a "cure." However, gender-affirming care is vital and saves the lives of many trans folks.[3]

In order to resist the historical pathologization of LGBTQ+ folks as inherently ill based on their identity,[4] trans-depathologization is described as a shift from conceptualizing gender transition as a mental disorder toward recognizing transition as a human right.[5] Depathologization aims not to eliminate the diagnostic category of transness entirely, as it serves to get care covered through insurance, but rather it views transness as a classification rather than an illness. While transness is still socially pathologized, the DSM has moved away from

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[1] Johnk, Lzz, and Sasha A. Khan. "'Cripping the Fuck Out:'A Queer Crip Mad Manifesta Against the Medical Industrial Complex." Feral Feminisms 9 (2019): 27-38.

[2] Mia Mingus, "Medical Industrial Complex Visual," Leaving Evidence, September 12, 2018, https://leavingevidence.wordpress.com/2015/02/06/medical-industrial-complex-visual/.

[3] Robin Christian et al., "Measuring the Health of an Invisible Population: Lessons from the Colorado Transgender Health Survey," *Journal of General Internal Medicine* 33, no. 10 (2018): 1654–60, https://doi.org/10.1007/s11606-018-4450-6.

[4] "Pathologization: Being Lesbian, Gay, Bisexual and/or Trans Is Not An ..." OAS, May 12, 2016. https://www.oas.org/en/iachr/media_center/PReleases/2016/064.asp.

[5] Christoph L. Hanssmann, *Care without Pathology: How Trans- Health Activists Are Changing Medicine* (Minneapolis, MN: University of Minnesota Press, 2023), 49.

categorizing transness as “gender identity disorder” to labeling it instead as “gender dysphoria.” Although these changes show progress towards depathologizing transness, it’s quite paradoxical that something that is specified to be “not a mental disorder” is still in the Diagnostic and Statistical Manual of *Mental Disorders.* Gender-affirming care can include things like hormone replacement therapy (HRT), gender-affirming surgeries, as well as therapy to help navigate feelings of physical and or social dysphoria. Depathologization activists have urged for gender-affirming care to be considered similarly to how healthcare for pregnant people is covered — not as something that inherently renders a person “ill,” but rather acknowledging standards of care that should be in place for gender-affirming care.[6]

Across the United States, increasing numbers of state-level legislations are being aimed at restricting the basic rights of trans people.[7] These bills are directed towards restricting trans people’s access to bathrooms, participation in sports, and access to gender-affirming healthcare. As of April of 2024, the numbers continue to skyrocket, with 539 bills proposed and 20 passed in *four months alone.*[8] While these bills were not passed in Colorado, their prevalence has been shown to significantly impact trans people’s access to medical care due to their fear of discrimination.[9] This delay in accessing medical transition has severe impacts on many trans people’s mental health, with many adults reporting depression and suicidal ideation. A significant way to mediate this is having access to safe, trans-inclusive medical providers who are knowledgeable about transness and the different options available for various forms of gender-affirming care.

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[6] Hanssmann, *Care without Pathology*, 45.

[7] Between 2010 and 2019, *189* anti-trans bills were proposed, and a total of 13 were passed. In 2023, that number skyrocketed — 600 bills were proposed, and *87* were passed.

[8] “2024 Anti-Trans Bills: Trans Legislation Tracker,” 2024 Anti-Trans Bills: Trans Legislation Tracker, accessed January 3, 2024, https://translegislation.com/

[9] Christian et al., “Measuring the Health of an Invisible Population.”

Through researching Colorado's legislative commitment to keeping trans medical care accessible, I aim to interrogate how Colorado is becoming one of the few "safe" states for accessing gender-affirming care and identify specific providers recommended by trans folks. Colorado's "safe-state" status has led to an influx of migration of trans people seeking gender-affirming medical care and resources. This migration is reshaping communities and trans care networks in many positive ways; however, it may also negatively impact wait times for medical care. Given this, the development of a comprehensive guide to accessing gender-affirming care seemed advantageous for the trans community. Therefore, this project aimed to build a community-based resource for trans care — from doctors and surgeons to affirming dentists and chiropractors, as well as community resources. Community resources, communities of trans people, and collective knowledge sharing have been historically essential in resisting pathologization within and outside of the trans community. These types of communities — conceptualized as "care webs" by Leah Lakshmi Piepzna-Samarasinha, a queer disabled nonbinary femme of color writer and disability and transformative justice activist — are grounded in ethics of interdependence, reciprocity, and collective responsibility.[10] These communities are crucial in resisting pathologization and collectively working against systems of oppression, and are often where a sense of belonging is found. Accessing trans care is a form of active rebellion and protest against anti-trans legislation, but knowing where and how to start can be overwhelmingly difficult. This project is an attempt to ease navigating access to gender-affirming care and identify collectively generated sites where trans care can be accessed throughout Colorado — a resource by trans people, for trans people.

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[10] Leah Lakshmi Piepzna-Samarasinha, 2019. "Care Webs," in *Care Work: Dreaming Disability Justice*. Third printing ed. Vancouver, BC: Arsenal Pulp Press. http://bvbr.bib-bvb.de:8991/F?func=service&doc_library=BVB01&local_base=BVB01&doc_number=031725187&sequence=000001&line_number=0001&func_code=DB_RECORDS&service_type=MEDIA.

Methodology

Finding and creating community is integral to queer and trans survival, but it can be challenging. These communities, however, are necessary spaces to feel belonging, to be able to articulate feelings of rage, happiness, and struggle, and are incredible spaces of knowledge. Despite this, I've noticed a lack of accessible information on gender-affirming care. Recognizing the need for straightforward and accessible information, I aimed to create a resource for affirming medical providers and community spaces informed by the experiences of trans individuals in Colorado.

I chose Colorado as my research site to give back to my community here, hoping to make their journey of navigating gender-affirming care easier and more accessible. From the sex-change capital of the world situated in Trinidad, Colorado, to the legal protections Colorado has recently placed to guard gender-affirming care, I wanted to delve deeper into the state's history and why it is now a legal safe haven. Colorado was not always a legal safe space for queer and trans people —In the 1970s, police targeted gay men by arresting them, and plain-clothes officers would arrest transgender sex workers.[11] For a brief period in 1975, a Boulder county clerk was issuing same-sex marriage licenses, but after facing a backlash that included death threats, the issuing ceased until the statewide legalization of same-sex marriage in 2014. The 1990s and 2000s were an improvement in legal protections outside of marriage for LGBT people. However, Denver became one of the first U.S. cities to have an anti-discrimination policy for gay and lesbian people in 1990, and in 2001, Colorado passed a hate crime law that protected people based on their sexual orientation and gender identity.[12] In recent years,

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[11] Law Week, By, and Law Week, "A Brief History of LGBT Rights in Colorado," Law Week Colorado, June 10, 2021, https://www.lawweekcolorado.com/article/a-brief-history-of-lgbt-rights-in-colorado/.

[12] ibid.

Colorado has joined with at least four other states in passing legal protections to shield transgender healthcare, first announcing these protections in 2021.[13] These laws help to address barriers that trans people often and continue to face and provide specific categories for essential health benefits.[14] In 2023, Colorado additionally signed a law that ensured the state would not participate in any out-of-state investigations involving providers or recipients of abortion or gender-affirming care that protect the individual as long as the activity took place in Colorado and there is no indication that anyone involved broke Colorado law.[15] However, these recent protections are building blocks and catalysts for change within legislative protection and have broader impacts on how trans care is conceptualized and experienced in the state.

A radical rethinking of care, through feminist scholars such as Queer and Trans Studies scholar Hil Malatino and Piepzna-Samarasinha, has been essential in informing what I consider to be trans care and helped me structure my research to include not only medical settings but community spaces as well. Valuing the voices and input of those most affected by the failure of these systems and spaces, the end product of my research – a compilation of Trans Health Resources in Colorado – is based on information given to me by the trans community in Colorado. Motivated by resisting the authority medical providers believe they have on what constitutes mental health and well-being, I chose to interview people to gather first-person accounts and experiences. Especially in minoritized communities, centering first-person experiences is a way to resist this claim to authority and expertise by professionals in a system that is dominated by gender violence within the broader contexts of white supremacy, eugenics,

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[13] Dana Ferguson et al., “Minnesota to Join at Least 4 Other States in Protecting Transgender Care This Year,” NPR, April 21, 2023, https://www.npr.org/2023/04/21/1171069066/states-protect-transgender-affirming-care-minnesota-colorado-maryland-illinois.

[14] Katie Keith, “Unpacking Colorado’s New Guidance on Transgender Health,” Commonwealth Fund, November 10, 2021, https://www.commonwealthfund.org/blog/2021/unpacking-colorados-new-guidance-transgender-health.

[15] Ferguson et al., “Minnesota to Join at Least 4 Other States in Protecting Transgender Care This Year,” NPR.

colonialism, and slavery. By choosing to interview people who have experience navigating the medical system, I aimed to center personal experiences, knowledge, and community-based resources in which people have found belonging.

I aim to critique the MIC and how it stigmatizes and renders abnormal any type of health or identity that is outside of white, able-bodied notions of "health." Using critical disability studies as a methodology, as scholar Julie Arvil Minch describes, "involves scrutinizing not bodily or mental impairments but the [. . .] social conditions that concentrate stigmatized attributes in particular populations."[16] Critical disability studies scrutinize these social norms that define and classify non-normativity as impairments. It additionally assesses how (dis)ability has been historically used as a social system, wherein racialized individuals were categorized as disabled, serving as a tool of management and marginalization that positions non-whiteness as non-normative and thus impaired or disabled.[17]

To begin building my resource, I started within my own circles, particularly seeking to consult trans people who had been in Colorado longer than four years and people with extensive networks and knowledge. This process consisted of asking my community, networking, emailing, and posting on social media. As a white genderqueer student at a predominantly white institution, my position lent credibility to my project and questions. My own transness also aided in giving the people I interviewed a sense of ease, not coming into this project as a cis outsider but indebted to the trans people of color who helped me graciously in being a mutual connection point for the people I interviewed. While prioritizing conversational interviews, I also created a

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[16] Julie Avril Minich. "Enabling Whom? Critical Disability Studies Now." Lateral 5, no. 1 (May 2016). https://doi.org/10.25158/l5.1.9, as quoted in Schalk, Sami. 2017. "Critical Disability Studies as Methodology." Lateral 6 (1). doi:10.25158/L6.1.13. https://explore.openaire.eu/search/publication?articleId=doajarticles::a1ec264ffbd4f728b0a75c79c35c6c3a.

[17] Sami Schalk, 2017. "Critical Disability Studies as Methodology." Lateral 6 (1). doi:10.25158/L6.1.13. https://explore.openaire.eu/search/publication?articleId=doajarticles::a1ec264ffbd4f728b0a75c79c35c6c3a.

survey to accommodate those who could not participate in an interview. With IRB approval, I conducted interviews covering various aspects of gender-affirming healthcare experiences in Colorado. Aiming to examine how people have experienced this process comprehensively, I asked about insurance issues, providers, their struggles and successes, and areas outside of the MIC where they have found community and care. While I garnered additional responses from my survey, it was a less comprehensive inquiry into people's experiences. Despite efforts to reach a representative demographic of trans people, the majority of people I interviewed were white and primarily from major metropolitan areas such as Colorado Springs and Denver, which undoubtedly influenced my analysis. Acknowledging my privilege as an upper-middle-class white person, I aimed to simplify access to gender-affirming care with input from trans people who have already navigated this process.

Critical Disability Studies and Queer and Trans Theories and Studies profoundly shape my conception of care. Piepzna-Samarasinha's work and Malatino's work demonstrate collective care models. Care can have multiple embodiments — such as care webs, communities, and resources, to name a few — but the underlying necessity and efficacy is care's accessibility. Access, as described by Piepzna-Samarasinha, is a form of radical love that prioritizes autonomy, joy, and sustainable community building. I emphasize Critical Disability Studies as a framework not only as a disabled person, but also because many trans people are also disabled or categorized as disabled or otherwise unwell due to their gender identity. Malatino, in "The Promise of Repair," discusses how care can include feelings such as rage —a feeling that often arises when dealing with a transphobic medical system. Malatino discusses how allowing manifestations of this rage can be restorative and motivational — an approach that motivated me to channel that rage into a project that would ease navigating trans rage. Action —through political protest, community organizing and defense, push for legal action and policy change, cultural and societal resistance, and mutual support — is often most effective in high numbers of collective participation. Communal action, resistance, and solidarity, with the support of large groups of people, have historically acted as catalysts for change.[18] Having communities and spaces that allow for trans rage to manifest also allows for it to be digested, legitimized, and worked through collectively, offering support for a feeling that is usually urged to be suppressed by a society that doesn't fully understand it. Malatino's book, *Trans Care*, radically rethinks trans care in ways that are informed by feminist and queer scholars of color, such as Piepzna-Samarasinha and Audre Lorde, and critiques dominant notions of care that are rooted in heteronormativity, racism, capitalism, and neoliberalism.

Literature Review

This literature review situates my project within the necessity of gender-affirming care, the pathologization of transness, and barriers to care. As Colorado is one of the few states that has placed legal protections on people accessing and providing gender-affirming care and has expanded insurance coverage for gender-affirming care, I focus on this state as a safe haven of sorts for people pursuing gender-affirming services. First, I discuss how gender-affirming care has the potential to significantly increase the quality of life and mental health of transgender people. Secondly, I discuss barriers to medical care that include but are not limited to race, class, disability status, and citizenship status. Finally, I examine how the historic pathologization and medicalization of transness have impacted people's access to and quality of care.

Gender-affirming care is a life-saving tool for many trans people struggling with

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[18] Malatino, Hil. "The Promise of Repair: Trans Rage and the Limits of Feminist Coalition." Signs: Journal of Women in Culture and Society, vol. 46, no. 4, 2021, pp. 827–851., https://doi.org/10.1086/713292.

dysphoria, and proper gender-affirming care can reduce suicidality and depression.[19] Research indicates that teens who desired and received pubertal suppressant treatment have been found to have lower lifetime rates of suicidal ideation than teens who wanted this treatment but couldn't access it.[20] In Sweden, individuals diagnosed with gender incongruence are more than three times more as likely to have received prescription treatment for depression and anxiety and more than six times more likely to be hospitalized after a suicide attempt.[21] Accessing this care goes beyond the treatment itself; it involves having a supportive network. Without ongoing community support, the benefits of medical gender-affirming care are restricted. Community care, including support groups and networks of understanding, play a vital role in improving the lives of trans people. Care within trans communities also often includes "complicit care" — theorized by feminist scholar and U.S. health public health analyst Chris Barcelos as care that simultaneously furthers marginalization and collective liberation within communities — and consists largely of trans-for-trans crowdfunding.[22] This crowdfunding is a common strategy used by many trans people to raise money for gender-affirming care, as well as survival expenses related to living in a transphobic world. While crowdfunding seems like an effective form of mutual aid, campaigns such as GoFundMe are more often than not underfunded, and the ones that are successful are most often raising money for white transmasculine people. This imbalance in funding frequently reproduces many of the inequities that it is a response to — notions of

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[19] Jennifer Schanzle et al., "4. Anti-Trans Legislation in the US: Potential Implications on Self-Reported Victimization and Suicidality among Trans Youth," *Journal of Adolescent Health* 72, no. 3 (2023), https://doi.org/10.1016/j.jadohealth.2022.11.018.

[20] Turban, Jack L., Dana King, Jeremi M. Carswell, and Alex S. Keuroghlian. "Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation." Pediatric Collections: LGBTQ+: Support and Care (Part 3: Caring for Transgender Children), 2021, 91–98. https://doi.org/10.1542/9781610025423-pubertal.

[21] Bränström, Richard, and John E. Pachankis. "Reduction in Mental Health Treatment Utilization among Transgender Individuals after Gender-Affirming Surgeries: A Total Population Study." *American Journal of Psychiatry* 177, no. 8 (August 1, 2020): 727–34. https://doi.org/10.1176/appi.ajp.2019.19010080.

[22] Chris Barcelos, "The Affective Politics of Care in Trans Crowdfunding," *TSQ: Transgender Studies Quarterly* 9, no. 1 (February 1, 2022): 28–43, https://doi.org/10.1215/23289252-9475495.

worthiness and who is deserving, white supremacy, adherence to gender normativity, and transmisogyny. When these financial contributions can't be met, however, this request for assistance generally also comes with solidarity and expressions of frustrated empathy, as well as sharing the request across different communities. Having access to care that enables people to re-enter public spaces and live a life that is most true to themselves can be truly transformational, but gaining access to this care is fraught with complications with insurance, discrimination, cost, citizenship status, and legibility. Access to gender-affirming healthcare is not only beneficial (and crucial) to the health and wellness of trans people but also often minimizes negative health outcomes of dysphoria-related mental health conditions and self-medication of hormone-replacement therapy.[23]

My Capstone project is primarily centered around trans care, which encompasses both access to essential medical gender-affirming tools and the importance of community care in making gender-affirming care accessible in the context of the MIC, transphobic laws, and also in spaces outside of the MIC where trans care is more fully understood. Despite some medical providers being knowledgeable of gender-affirming care, inclusive, and affirming through the use of correct pronouns and terminology that does not conflate gender with sex, transphobia is embedded within the MIC. As the MIC is a complex structure in which racialized transphobia is deeply embedded, I aim to critique the system at large and not simply solely individuals who are working within the system. Situated as a neoliberal system of healthcare within the United States, the MIC's underlying notions of normativity and wellness mandate gender-affirming care under the expectation of producing an abled body not only in terms of gender and sexuality normativity, but also in terms of economic productivity, as described by critical disability studies

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[23] Christoph L. Hanssmann, *Care without Pathology: How Trans- Health Activists Are Changing Medicine* (Minneapolis, MN: University of Minnesota Press, 2023), 165.

and cultural ethnic studies scholar Jasbir Puar.[24] Therefore, accessible and holistic gender-affirming care in which bodily autonomy is centered is difficult to come by in a system that regards trans bodies as inherently "ill" and "disabled." Unnecessary barriers to gender-affirming care are pervasive and stigmatized — including but not limited to mental health evaluations before access is granted to HRT, systems of identification that don't ask for a preferred name and continuously deadname and misgender patients, explicit refusal from some providers who "aren't comfortable" treating trans people, and pathologizing and stigmatizing transness. Under the MIC, gender-affirming care is often separate from a more broadly encompassing type of care through this inherent transphobia. A more broadly encompassing type of care is often referred to as "trans care," which can be present within the MIC but is more often present in spaces outside of it, through communities and support networks. Trans care has been theorized by Queer and Trans Studies and Theory scholar Hil Malatino as an emergent ethos resisting conceptualizations of care as a form of debt (read: burden) and emphasizes its interdependent communal nature as an act that fosters survival for trans people.[25] By this, Malatino proposes care as not an act of charity, but rather something the community can provide to each other that doesn't feel obligatory or mandatory. Trans healthcare, more specifically, refers to the "regular healthcare that non-trans people receive every day when they need it - but that is specifically denied to trans people."[26] Moreover, trans health is bodily autonomy, in which trans people "enhance our collective knowledge so that the means to understand our bodies is universally available."[27]

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[24] Jasbir K. Puar, "Bodies with New Organs," Social Text 33, no. 3 (September 1, 2015): 45–73, https://doi.org/10.1215/01642472-3125698, 47.

[25] Hil Malatino, Trans Care (Minneapolis, Minnesota: University of Minnesota Press, 2020).

[26] Jase Peeples, "GLAAD Urges N.Y. Gov. to Help Trans New Yorkers Get Needed Health Care," Advocate.com, November 17, 2015, https://www.advocate.com/politics/transgender/2013/11/15/glaad-urges-ny-gov-help-trans-new-yorkers-get-needed-health-care.

[27] Edinburghath, "Edinburgh Action for Trans Health on Tumblr: Trans Health Manifesto," Tumblr, July 28, 2017, https://edinburghath.tumblr.com/post/163521055802/trans-health-manifesto.

While trans healthcare can be accessible, albeit scarcely in the MIC, trans health emphasizes collective knowledge sharing through community. ” Malatino stresses additionally the importance of trans communities, stating that these spaces allow trans rage to be broken down and processed and can be an entry into collective trans joy, an expression that seeks to reject and destroy the conditions that enable such rage.[28] This trans rage Malatino discusses often comes from the inaccessibility of care, as well as legal factors such as anti-trans bills directed towards restricting trans people’s access to public bathrooms, participation in sports, changing one’s name and sex markers on legal documents, and overall access to gender-affirming healthcare. Having these community-building spaces for trans people to navigate gender-affirming care collectively allows people to share resources and process feelings that non-trans people may not readily understand.

Barriers to gender-affirming care in Colorado, specifically, have been identified as discrimination, prohibitive cost, and difficulty finding transgender-inclusive providers,[29] and more largely as the stigma surrounding factors such as race, class, insurance coverage, disability, and citizenship status. While areas like Denver and Boulder have centers for queer and trans people, people in more suburban or rural areas may not have access to or know about resources in closer proximity to them. Areas such as Colorado Springs are somewhat lacking in providers that are within an hour or hour and a half drive. While being close to Denver allows for travel to providers, many people don’t have the resources or time to journey outside of their town to access care, especially routine care such as monthly HRT appointments. Experiences of trans people, even within Colorado, are not generalizable, however. Implications for trans people of

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[28] Hil Malatino, “The Promise of Repair: Trans Rage and the Limits of Feminist Coalition,” *Signs: Journal of Women in Culture and Society* 46, no. 4 (2021): 827–51, https://doi.org/10.1086/713292.
[29] Christian et al., “Measuring the Health of an Invisible Population.”

color in Colorado include significantly greater odds than white trans people of having autoimmune disorders and asthma but lower odds of being told they had depression, while trans people with lower income had significantly worse mental and physical health.[30] Seelman et al., in their study “A Comparison of Health Disparities among Transgender Adults in Colorado (USA) by Race and Income,” additionally found that transgender adults had elevated rates of high blood pressure, poor physical health, higher proportions of fair/poor overall health, and more days in a month in which health issues kept them from doing their daily activities in comparison to Colorado adults in general.[31] Furthermore, researchers found that transgender adults in this study averaged almost eight days more of poor mental health in the past month compared to Colorado adults in general, as well as notably higher rates of current depression, anxiety diagnosis by a doctor, and suicidal ideation. Researchers tied these reasons for increased mental health issues for transgender people to social stigma, rejection from family members, lack of social support, and limited availability of culturally competent behavioral health services in parts of the country. Transgender people of color’s increased odds of having autoimmune disorders or asthma are likely linked to environmental racism and increased exposure to environmental toxins, and further, sustained exposure to experiences of stress, such as racism, compound the stress of transphobia, which all work to exacerbate health disparities among trans people of color. Additionally, trans people of color are often subjected to racialized transphobia, which is the intersectional discrimination faced by the material factors of race and transness, and manifests in how racialized subjects are already treated as gender deviant, such as the stereotypes

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[30] Kristie L. Seelman et al., “A Comparison of Health Disparities among Transgender Adults in Colorado (USA) by Race and Income,” *International Journal of Transgenderism* 18, no. 2 (2016): 199–214, https://doi.org/10.1080/15532739.2016.1252300.

[31] Seelman et al., “A Comparison of Health Disparities among Transgender Adults in Colorado (USA) by Race and Income.”

of the hypersexual black person or the effeminate Asian man.[32] This furthers the vulnerability BIPOC face when accessing medical care under a racist healthcare network that already stereotypes people of color and pathologizes transness.

In addition to these racial disparities, significant disparities among transgender people with and without inclusive providers were found in Colorado. “Measuring the Health of an Invisible Population: Lessons from the Colorado Transgender Health Survey” found that a large number of transgender or gender-nonconforming adults living in Colorado reported delaying medical care due to cost, inadequate insurance, and/or fear of discrimination. Survey respondents also reported significant mental health concerns — 43% reporting depression, 36% reporting suicidal thoughts, and 10% attempted suicide in the past year.[33] Respondents with a transgender-inclusive provider, however, reported a higher probability of receiving wellness exams, were less likely to delay care due to discrimination, reported less depression, and were less likely to attempt suicide than those without. These findings underscore the undeniable influence of barriers to care on transgender individuals and underscore the necessity of inclusive healthcare providers.

Barriers to care are often compounded by race, class, disability status, and citizenship status.[34] Racial disparities in healthcare are not a new phenomenon by any means, and they undoubtedly impact the way one’s physical and mental health are treated. In the United States, Black people have higher rates of mortality and morbidity than white people, and Hispanic people and American Indians have higher disease and death rates for multiple conditions.[35]

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[32] Chris Barcelos, “The Affective Politics of Care in Trans Crowdfunding,” TSQ: Transgender Studies Quarterly 9, no. 1 (February 1, 2022): 28–43, https://doi.org/10.1215/23289252-9475495, 70.

[33] Robin Christian et al., “Measuring the Health of an Invisible Population.”

[34] Seelman et al., “A Comparison of Health Disparities among Transgender Adults in Colorado (USA) by Race and Income.”

[35] D R Williams and T D Rucker, “Understanding and Addressing Racial Disparities in Health Care,” Health care

Within the domain of psychology — which plays a major role in diagnosing transness as a "disorder" for insurance to cover treatment — cultural perceptions and assumptions often influence how people are treated. Psychologists often overemphasize the role of culture in the behavior of racial and ethnic minorities (cultural (mis)attribution), leading them to favor cultural explanations for behavior over psychological explanations and results in people of color receiving less intensive psychological treatment for possible mental health conditions.[36]

Transphobia and racism are highly intersected, as notions of gender normativity are rooted in expectations of whiteness, and this creates even more barriers for trans people of color and impacts the access and quality of the care they receive. Cultural (mis)attribution, economic disparities in insurance coverage, and dominant conceptions of transness as "non-normative" and "unusual," compounded by the historical abuse of Black enslaved people as test subjects for developing medicine, all affect how many medical providers view and treat trans people of color. Binaries that view race and gender as "fixed" or "one or the other" allow medical providers to keep their beliefs unchanged. C. Riley Snorton, a cultural theorist whose work focuses on historical perspectives of Black transgender identities, explores the historical intersection of Blackness and transness throughout the nineteenth and twentieth centuries in America. Snorton draws on the treatment of Black enslaved women as test subjects in the development of modern gynecology, how cross-dressing enabled escape for some enslaved people and the ungendering and fungibility of Black enslaved people. People of color, in the development of American medicine, were treated as "bodies" and "consistently read as less plastic [changeable or treatable], as less evolved sexually, and thereby less worthy of medical care," as Jules Gill-

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financing review, 2000, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194634/.

[36] José M. Causadias, Joseph A. Vitriol, and Annabelle L. Atkin, "Do We Overemphasize the Role of Culture in the Behavior of Racial/Ethnic Minorities? Evidence of a Cultural (Mis)Attribution Bias in American Psychology.," *American Psychologist* 73, no. 3 (2018): 243–55, https://doi.org/10.1037/amp0000099.

Peterson describes in "Trans of Color Critique before Transsexuality."[37] In *Black on Both Sides,* Snorton discusses how refusing this binary logistic of race and gender could demonstrate how to think expansively about how Black studies and trans studies offer insights that surpass an "additive logic."[38] Resisting this additive logic is crucial to understanding how people's social situations can aggravate their experiences. This history is not lost — while its material effects may go unnoticed and overlooked by many medical providers as well as transgender studies at large, the repercussions of this history not only impact trans-of-color studies but also inform how people of color often get (mis)treated in medical settings or regarded as lesser-than their white trans counterparts. Specifying trans of color studies is integral as it reveals how the whiteness of transsexuality actively undermines the intelligibility and material visibility of trans-BIPOC, rendering them more invisible, marginal, or exceptional than they would otherwise be in transgender studies as a field."[39]

Another dominant narrative trans activists continually seek to resist is the pathologization of transness. In other words, trans activists seek to dismantle how transness is identified as something that is inherently disordered, non-normative, or constitutive of mental disorder. This pathologization shows up materially when seeking gender-affirming care — many surgeons and prescribing physicians in the United States and across the world require letters of authorization from licensed mental health providers before people are allowed to seek affirming care.[40] This is partially due to what Christoph Hanssmann calls the "illness-care conundrum," which describes

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[37] Julian Gill-Peterson, "Trans of Color Critique before Transsexuality," TSQ: Transgender Studies Quarterly 5, no. 4 (November 1, 2018): 606–20, https://doi.org/10.1215/23289252-7090073, 610.

[38] C. Riley Snorton, *Black on Both Sides: A Racial History of Trans Identity* (Minneapolis, MN: University of Minnesota Press, 2017), 7.

[39] Julian Gill-Peterson, "Trans of Color Critique before Transsexuality," 615.

[40] Christoph L. Hanssmann, *Care without Pathology: How Trans- Health Activists Are Changing Medicine* (Minneapolis, MN: University of Minnesota Press, 2023), 67.

the difficulty of providing or accessing care without a specified, diagnosable illness.[41] Most medical providers often need to diagnose someone with an illness that is connected to a code that insurance companies use for billing. This shows up most often in the United States for trans people as a diagnosis of "Gender Dysphoria," a category in the DSM-5. While this does provide insurance coverage for certain individuals, it requires the diagnosis of a mental illness. The DSM-5 serves as the primary standard for diagnosing mental disorders in the U.S. and encompasses conditions such as schizophrenia, bipolar disorder, depression, and generalized anxiety disorder. This conflates transness with mental illness while stigmatizing and instilling fear in trans people seeking care.

Depathologizing transness is a necessary task for medical and psychological frameworks in order for trans individuals to access the life-saving care that they need. In thinking about how factors such as race, class, and disability already impede access to care, depathologizing transness has important implications for people who may already be struggling to access or receive care based on other factors. *Care Without Pathology,* a recent book by biomedicine and social movement scholar Christoph Hanssmann, examines how medical and therapeutic approaches to transgender patients have radically changed from treating a supposed pathology to offering gender-affirming care. In essence, trans depathologization aims not to eliminate the diagnostic category of transness entirely, as it serves as a pathway to care.[42] Rather, it advocates for a transition from viewing it as a mental health condition to merely a classification. This shift is analogous to how pregnancy is categorized — pregnant individuals are not inherently considered ill, but there are standards of care specific to 'pregnancy,' enabling insurance coverage without the classification of illness. Hanssmann characterizes care without pathology, then, as

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[41] Hanssmann, *Care without Pathology*, 53.

[42] Hanssmann, *Care without Pathology*, 49.

involving affirmation of identity, asserting a right to healthcare, and outright denial of transgender identity as an illness. However, for others, it primarily involves advocating for necessary resources to improve the quality of life for those who have been marginalized or excluded due to societal norms or structures that have caused illness or invisibility. These life-enabling conditions can look like access to gender-affirming care that allows someone to feel more comfortable in their presentation, surgeries that allow one's body to align more with their mind, and in some cases, the ability and privilege to "pass" as a certain gender that can often grant safety and feelings of belonging.

The historical pathologization of transness has significantly impacted the experiences and access to care for transgender individuals. While progress has been made in gender-affirming therapies and surgical procedures, considerable barriers persist, including the continued reliance on diagnostic categories such as "Gender Dysphoria" in the DSM-5, the cost of care, and the difficulty in finding trans-inclusive providers. The necessity for gender-affirming care is evident in its potential to enhance the quality of life and mental health for transgender individuals. Community care plays a vital role in navigating and addressing these challenges, offering spaces for mutual support, understanding, and the sharing of resources. This shift of depathologization is essential for ensuring that trans people can access life-saving care without being stigmatized or required to conform to diagnostic categories. Depathologization represents a movement toward recognizing gender transition as a human right, emphasizing affirmation, and rejecting the notion of transness as an illness.

Analysis

Gender-affirming care can look like affirming and accessible access to medical care (including but not limited to HRT, top surgery, bottom surgery, and facial feminization surgery), as well as seemingly mundane care such as barber shops and hair salons, chiropractors, vocal trainers, and support groups. These are all spaces and places that can be difficult to access for a variety of factors, but with increasing anti-trans legislation, gender-affirming medical care is being targeted with especially intense pressure. Bills seeking to deny gender-affirming care increased by five times in 2023, and since the beginning of 2024, over 130 bills targeting trans healthcare have been introduced.[43]The pathologization of transness not only impacts how care can be received and covered but also renders the very conditions of transness *ill* and, therefore, in need of “curing” or concealing. “Curing” transness or concealing gender non-conformity to the public eye has been described by trans studies scholar Tony Beauchamp as not simply erasing the transgender status but also necessitates conforming one’s gender presentation to white, middle-class, able-bodied, and heterosexual notions of gender normativity.[44] The “cure” then of transness is not an internal or mental reformation, but rather the ability to conform to multiple social norms and blend into society at large.[45]

In interviewing trans people in the greater Colorado Springs area, many brought up encounters with primary care providers (PCPs) who were not knowledgeable about gender-affirming care, such as HRT, or options that trans people have if they wanted to seek medical gender-affirming care. The burden of knowledge and teaching then shifts to the patient, even though they seek doctors' expertise and rely on them as authorities who can prescribe medication. Respondents who had experience with affirming medical providers noted that these providers not only had a baseline understanding of trans medical care but were willing to research things that their patients brought up and educate themselves if they were uninformed.

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[43] “2024 Anti-Trans Bills: Trans Legislation Tracker,” 2024 Anti-Trans Bills: Trans Legislation Tracker, accessed January 3, 2024, https://translegislation.com/.

[44] Puar, “Bodies with New Organs,” 53.

[45] Ibid.

Ignorant providers are not the worst providers people can face, however. Some trans people discussed how they encountered PCPs who were uncomfortable treating trans patients, so they simply refused any sort of interaction with them at all. Not only is this dehumanizing and unethical, but the irony is that much of the gender-affirming care that trans people seek out is the same care that cis people seek (i.e. estrogen, which is prescribed to many cis women experiencing menopause; testosterone, which is prescribed to cis men with low testosterone, just to name a couple). In legal battles to get gender-affirming care covered by insurance, attorneys have argued that non-trans women regularly receive Medicaid coverage for hormone replacement therapy, and non-trans men can get coverage for what is essentially top surgery for conditions such as gynecomastia (a condition in which breast tissue is overdeveloped or enlarged in cis men). Despite this, judges and health officials consistently maintain that trans healthcare and gender-affirming care for non-cis people is “different” and “experimental,” and therefore does not meet eligibility standards.[46]

These “eligibility standards” drive insurance companies' motivation to cover some services, not others. By covering gender-affirming care (which is largely thought of as just *healthcare*) for cis people but not covering the same procedures and medications for trans people, medical providers, and insurance companies create a double standard of care that reinforces gender hierarchies and medical authority, all while undermining the self-determination, self-awareness, and self-advocacy of trans people. When non-cis[47] people want gender-affirming care, the process is typically lengthy and involves multiple doctors — most

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[46] Hanssmann, *Care without Pathology,* 154.

[47] In this instance, I use “non-cis” rather than “trans” to more accurately encapsulate the broad range of people who may seek gender affirming care. Some genderqueer, androgynous, butch, or people who resist labels may not identify fully with the term “trans,” but may pursue gender affirming care to feel more comfortable in their body and gender presentation.

surgeons and prescribing physicians in the United States require letters of authorization from licensed mental health providers before proceeding.[48] These letters of authorization and other forms of legitimacy can often take months on end, which further prolongs an already long process that has been shown to improve the overall quality of life and well-being of trans people. Not to mention, these letters and forms are not always affirming in and of themselves — asking deeply personal questions about one's life, sex life, dating life; essentializing one's body to the sex one was assigned at birth; and overall intrusive questions that should not affect whether or not a person has bodily autonomy and the main say in what their medical care looks like. These issues were common frustrations brought up in many of the conversations I had with people who were successful in finding gender-affirming care, and even though they were successful, a lot of unnecessary time and effort was put into fighting for their care in the first place. These frustrations drive the need for a resource compiling accessible gender-affirming in Colorado in the hopes of reducing people's interactions with non-inclusive (and oftentimes transphobic) providers.

The underlying issue here in nearly every instance is insurance. Even those with the most affirming care providers likely have to jump through hoops to get prescriptions and procedures covered, as insurance companies require some form of diagnosis to provide access to covered or subsidized care.[49] While the DSM has moved away from categorizing transness and gender nonconformity as a *disorder* (formerly named "Gender Identity Disorder") to focusing on the distress it can bring, now labeling it as "Gender Dysphoria," not all insurance companies are willing to or able to provide coverage for "transgender healthcare." Some providers have found loopholes around this necessity of diagnosis of a gender-related disorder and can instead

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[48] Hanssmann, *Care without Pathology*, 66.

[49] Hanssmann, *Care without Pathology*, 53.

diagnose patients with "endocrine disorder," which allows for the coverage of hormone replacement therapy in some cases. These loopholes are not fixes or permanent solutions for insurance issues and usually are only able to offer temporary coverage before suspicion arises on the insurance end. These circumstances, as well as the varied but ever-present manifestations of racialized transphobia, medical and employment discrimination, abandonment and exclusion by states, and the subsequent desperation that sets conditions for diminished mental health and well-being, have inspired activists to fight for increased Medicaid and insurance coverage. In 2016, New York-based activists claimed, through the Cruz v. Zucker case, that both social belonging and financialized care should be accessible for trans people on Medicaid, and won.[50] While this legal victory doesn't apply nationally, it sets a tone and an expectation of what can and should be done regarding insurance coverage, especially through state coverage, as a lot of gender-affirming care is still not covered easily on state and even private insurance. Insurance companies additionally can construct their own meaning of "health," which often shifts contextually (especially when a lot of insurance in the U.S. is for-profit), to designate who gets labeled as "healthy" or "unhealthy."[51] Insurance conceptions of health, however, are often rooted in ableist assumptions of what a body "should" do, bio-essentialist notions of what gender "should" be and look like, and the Medical Industrial Complex's core motivations, which are eugenics, charity and ableism, population control, and desirability.[52] One woman I spoke with — a white Jewish trans woman in her 30s — had to get a union involved to get her employer-issued insurance to cover her facial feminization, a process that was long and grueling. While it ultimately catalyzed a change and prompted the insurance company to cover more gender-

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[50] Hanssmann, *Care without Pathology*, 182.

[51] Zena Sharman, essay, in *The System Isn't Broken, It's Working as Designed* (Vancouver, BC: Arsenal Pulp Press, 2021), 44.

[52] Ibid.

affirming care, her frustrations with the process and dealing with insurance should not be overlooked or simply praised as successful activism. Trans people should not have to engage in these fights to get procedures that are gender-affirming and enhance their overall well-being covered under insurance just to be able to get the procedures done in the country. Another trans woman I spoke with traveled to Marbella, Spain, after discovering that Medicare does not cover FFS and paid out of pocket to get the procedure done there— a privilege most don't have.

In light of the issues with insurance, even more complexity and challenges arise for people in need of gender-affirming care who do not have insurance. Providers of people who cannot conceivably afford the costs of paying for hormone prescriptions out of pocket have noted that these people would likely still seek out ways to get hormones, turning to informal markets that are potentially dangerous and unjust.[53] Even in providing tools to secure coverage for life-saving, gender-affirming healthcare through insurance, an implicit presumption of insurance coverage assumes a level of accessibility that excludes individuals lacking such coverage, thereby relegating them to the outskirts. Obtaining insurance is met with multiple barriers, intricately interwoven with historical processes of racialization, criteria for citizenship eligibility, socioeconomic status, and access to employment. Consequently, for many trans people, the absence of insurance proposes a dilemma characterized by either enduring the significant distress often caused by dysphoria or resorting to the utilization of unofficial and unregulated HRT, which is inherently fraught with dangerous consequences. Focusing the trans healthcare crisis solely on issues of insurance subverts the structural issue of insurance processes and obtainment at large and places the responsibility for navigating the system on the individual rather than looking at the broader issue of the fundamental risk factors that put people in these precarious

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[53] Hanssmann, *Care without Pathology*, 102-103.

and vulnerable situations in the first place.[54] The benefits associated with privilege, such as access to insurance that covers gender-affirming care, come not only from one's material advantages but also from the material advantages that come when these privileges are combined at a group level.[55] Even if access to insurance and insurance policies change to benefit those in need, a societal understanding of transness as an identity rather than an illness is necessary.

Despite the shift in categorizing transness in the DSM from Gender Identity Disorder to Gender Dysphoria, many depathologization activists still critique its presence in a manual of mental health disorders, as it still stigmatizes and pathologizes transness as a mental illness and an illness at large.[56] Other providers, activists, and advocates regarded the shift to the Gender Dysphoria diagnosis as a compromise that still allows gender-affirming care to be covered under insurance without the stigmatization of "disorder" in the title but still hope to move away from a DSM category entirely to destigmatize trans healthcare further.[57] Conversely, some attorneys and physicians such as Chase Strangio and R. Nick Gordon critique this shift, noting that it has the potential to intensify barriers to trans healthcare for people in situations of confinement, such as jails, prisons, psychiatric institutions, and immigration detention.[58] These institutions commonly neglect even the most basic care, let alone trans healthcare, and the shift to a framework of "distress" rather than "disorder" may give these institutions further justification for their medical neglect. Despite the shift from a "disorder" diagnosis to more of an identity and or distress-based framework in the DSM revision, Quincy Meyers, a women, gender, and sexuality scholar, has noted that this shift alone also does not automatically address the whiteness and coloniality

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[54] Link and Phelan 1995:85. Quoted in Reynolds, "Health Power Resources Theory: A Relational Approach to the Study of Health Inequalities," 494.

[55] Reynolds, "Health Power Resources Theory: A Relational Approach to the Study of Health Inequalities," 496.

[56] Hanssmann, *Care without Pathology*, 93.

[57] Ibid.

[58] Ibid.

embedded in our modern understandings of sex/gender.[59] These modern understandings of sex/gender, largely formulated by the long history of racism, colonialism, and the historically persistent exploitative abuse of people of color's bodies, direct societal assumptions of racialized gender, as well as normativity. Some eighteenth-century colonial doctors decided to operate on white bodies that were considered "ambiguous" (i.e. not conforming to binary standards of sex) but deemed necessary for surgery that was "normalizing," but these operations would not be considered for similarly "ambiguous" Black people who were not conforming to binary sex because, even if they were conforming to binary sex expectations, their Blackness inherently disturbed colonial ideas of sex.[60] While these notions may not be so overt in medical decision-making today, there are undoubtedly still structures of decision-making and medical practice that regard non-white bodies as inherently "deviant," "ambiguous," "more tolerable to pain," and overall less worthy or needing medical treatment. Medical structures continue to perpetuate racialized gender as the norm, something inherent to our society, and or the "necessary and naturalized consequence of the current order of things," Black trans scholar C. Riley Snorton notes.[61] When cisgender identity is analogous to normalcy and trans identity is analogous to deviancy, gender-based social inequality is embedded into all institutions.[62]

The pathologization of transness and the necessitation of a "cure" lies within the broader context of medicalization, which identifies trans people as problems that can only be solved by specialized biomedical observation and diagnosis of, treatment of, and management of an

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[59] Quincy Meyers, "Strange Tensions," TSQ: Transgender Studies Quarterly 9, no. 2 (May 1, 2022): 199–210, https://doi.org/10.1215/23289252-9612851, 206.

[60] Meyers, "Strange Tensions," 205.

[61] C. Riley Snorton, Black on Both Sides: A Racial History of Trans Identity (Minneapolis, MN: University of Minnesota Press, 2017), ix.

[62] England, Evan Thomas, "Transgender Health: Exploring Medicalization and the Interactions of Race/Ethnicity, Disability, and Education" (2022). Master's Theses and Capstones. 1644. https://scholars.unh.edu/thesis/1644, 4.

illness.[63] The notion and historic categorization of transness as a “Gender Identity Disorder” medicalizes the trans identity and furthermore implies that trans people are predisposed to the development of physical and mental health disorders while assuming that they are mentally ill to begin with.[64] This is often seen in the assumption by doctors that all trans people should seek to modify their bodies in such a way that resembles typical cisgender bodies, which trans scholar and nurse soma navidson calls “transnormativity.”[65] Transnormativity encourages trans people to make their bodies mirror cis bodies to whatever extent possible while offering no other options — a model of care that not only reinforces gender essentialism but also whiteness.[66] The process of diagnosis and treatment reinforces this as well, as medical surveillance first focuses on a person's legibility as trans and, following medical interventions, focuses on their ability to conceal their trans status or gender deviance.[67]

As Primary Care Providers (PCPs) are the most common point of contact with the health system that trans people have, it is crucial for them to have proper and effective training on widespread medical conditions and treatment plans.[68] Not only would that allow for better support of the needs of all patients, especially trans patients, but it would broaden their understanding of comprehensive health care and when consulting specialty providers is appropriate. As access to specialty providers can be challenging due to long wait times, needs for referrals, and spotty insurance coverage, increased awareness and understanding of transgender

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[63] Michelle Wolff, David A. Rubin, and Amanda Lock Swarr, “The Intersex Issue,” *TSQ: Transgender Studies Quarterly* 9, no. 2 (May 1, 2022): 143–59, https://doi.org/10.1215/23289252-9612767, 143.
[64] England, "Transgender Health."
[65] soma navidson, “Unlearning: Improving Trans Care by Reorienting Medical and Nursing Discourse,” essay, in The Remedy: Queer and Trans Voices on Health Care (Vancouver: Arsenal Pulp, 2016), 37, quoted in Meyers, "Strange Tensions,” 205.
[66] Meyers, "Strange Tensions,” 205.
[67] Puar, “Bodies with New Organs,” 53.
[68] Sam Winter et al., “Synergies in Health and Human Rights: A Call to Action to Improve Transgender Health,” The Lancet 388, no. 10042 (July 2016): 318–21, https://doi.org/10.1016/s0140-6736(16)30653-5.

healthcare by PCPs would allow for increased support of the mental and physical well-being of trans patients.

The most affirming and beneficial experiences highlighted by the trans people I interviewed started with providers who were knowledgeable about trans healthcare — and if providers weren't knowledgeable, they were willing and able to do the necessary work of educating themselves on areas their patients were seeking guidance on. In my own experience, the most affirming and comprehensive medical care has come from trans providers themselves, who assume nothing of my own transition goals and continuously work to educate me on the possibilities there are and how best to feel affirmed in my body. An intersex trans man of color in the military I spoke with echoed similar sentiments — his PCP was knowledgeable on gender-affirming care and led him in the right direction to pursue gender-affirming care even further. This made him feel supported and affirmed — a feeling he wasn't used to being in the "don't ask, don't tell" mindset of the military, and growing up intersex around people who weren't educated and confused about his body. His PCP was educated and willing to sign whatever forms he needed to pursue further care, without burdening him with endless unnecessary questions or subjecting him to judgment. Another person I spoke with, a white trans woman in her 70s, discussed how her experience improved greatly after she switched PCPs and found someone who was not only knowledgeable in HRT but also valued her experiences and believed in blood testing and working through the process of HRT management. However, these affirming providers are hard to come by and often are accompanied by long wait times. A non-binary trans masculine person in his 30s I spoke with noted how difficult it was to find a PCP who was willing to manage HRT. Compounded by the limits of their employer-provided insurance and the high demand for providers who were actually gender-affirming, they encountered many providers who were labeled as gender-affirming but were unwilling to manage HRT, and providers who were simply “uncomfortable” with trans people and refused to work with them. These experiences are unfortunately overwhelmingly common, and even when providers themselves are affirming, the offices and administration are often not, as many of the people I spoke with noted.

While experiences in the medical system varied greatly between each person I spoke to regarding gender-affirming care, there was one thing common in all of them — the unwavering, restorative, and compassionate support of one’s community. From having other trans people accompany them to doctor appointments, to having friends and partners advocating for them when they’re being mistreated and unable to advocate for themselves, and being able to attend support groups with other trans people, community was the most common denominator when I asked people where they found the most support outside of medical settings. This kind of care, theorized by Leah Lakshmi Piepzna-Samarasinha as “care work,” is a kind of labor that involves caring for oneself and others and focuses on fostering survival — most often within marginalized communities.[69] This work is often overlooked but is essential for community survival and solidarity, and focuses on building community and collective access as a type of revolutionary love without charity, in which community lifts up those in need.

Care work can have various embodiments — in community resources, areas catered towards community building and solidarity, spaces for relationship building — but even in affirming spaces for the seemingly mundane tasks such as going to the dentist, getting a haircut, or seeing a chiropractor. Gender-affirming care is not exclusively medical care — and sometimes doesn’t include medical care at all. Some trans and or non-cis people are content with their body

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[69] Piepzna-Samarasinha, “Care Webs.”

and don’t seek out medical transition-related care, but deserve to feel affirmed in the same ways that trans people who do pursue medical transition do. Non-medical gender-affirming care can include getting a haircut that makes someone feel more comfortable in their body, access to vocal training to shift one’s voice without medical intervention, shopping for clothes that make someone feel empowered and alleviate dysphoria, the ability to use the bathroom of one’s choosing safely, and or the ability to modify one’s body in the form of tattoos or piercings. These all can be incredibly gender-affirming, but only if the environment in which they are in is safe, open, accepting, and acknowledges and affirms not only their identity, but their existence. Regardless of one’s pursuit of medical transition or not, non-cis, cis, and trans people alike all need community spaces and spaces where they feel comfortable and affirmed while tending to their personal care. Community, collectivity, and understanding are all integral parts of human life, but in areas that lean more conservative or even in settings in which there is uncertainty about the safety of the people in them, it’s even more essential to have dedicated, secure environments in which those fears are at ease. Trans healthcare *is* these spaces of community, knowledge sharing, and the ability to digest and cope with the rage and discrimination that often comes from existing in a society that is so ingrained in white, heteronormative, binary constructions of not only gender but identity as a whole. Collectivity and survival are built within communities through mutual support — livelihood and wellness are manifested most effectively under collectively supported conditions that build off of each other in the forms of care work and in spaces that are not only accepting but embracing of all types of people, and resistant of white supremacist notions of identity.[70]

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[70] Nat Raha, “Embodying Autonomous Trans Health Care in Zines,” *TSQ: Transgender Studies Quarterly* 8, no. 2 (May 1, 2021): 188–98, https://doi.org/10.1215/23289252-8890565, 189

Conclusion

In conclusion, the journey through understanding and advocating for gender-affirming care in Colorado highlights a complex landscape shaped by historical legacies, systemic biases, and ongoing struggles for recognition and equality. As the intricate web of medical, legal, and social frameworks is navigated, it becomes clear that the path to comprehensive care is fraught with challenges, yet paved with resilience and determination. Gender-affirming care encompasses a spectrum of medical interventions, from hormone therapy to surgical procedures, but extends beyond clinical settings to encompass everyday spaces and interactions. It is a testament to the multifaceted nature of identity and the diverse ways in which individuals seek validation and empowerment. However, the systemic barriers entrenched within insurance policies, medical practices, and societal norms continue to impede access and perpetuate disparities.

The pathologization of transness, rooted in historical medicalization and societal prejudices, underscores the urgent need for depathologization and recognition of trans identities as valid and deserving of respect. While strides have been made in shifting diagnostic frameworks and legal protections, persistent biases and discriminatory practices persist, posing significant obstacles for those in need of gender-affirming care. The experiences shared by trans individuals in Colorado reflect the varying experiences of folks navigating gender-affirming care. Affirming providers offer hope, yet their scarcity and the barriers of insurance coverage underscore the urgent need for systemic change. Community support emerges as a vital lifeline, providing solidarity, advocacy, and a sense of belonging amidst a landscape fraught with adversity. As the complexities of trans healthcare are confronted, it becomes necessary to center the voices and experiences of those most affected and to advocate for policies and practices that prioritize accessibility, affirmation, autonomy, and self-determination — something that can be done through collective action, informed advocacy, and solidarity. This resource, shaped by insights from trans people who have directly navigated and experienced the (oftentimes intricately horrific) process of accessing gender-affirming care, aims to simplify and enhance the process for those beginning their journey or seeking to enhance the quality of care they receive.

Works Cited

"2024 Anti-Trans Bills: Trans Legislation Tracker." 2024 Anti-Trans Bills: Trans Legislation Tracker. Accessed January 3, 2024. https://translegislation.com/.

Barcelos, Chris. "The Affective Politics of Care in Trans Crowdfunding." *TSQ: Transgender Studies Quarterly* 9, no. 1 (February 1, 2022): 28–43. https://doi.org/10.1215/23289252-9475495.

Beauchamp, Toby. "The Substance of Borders." *GLQ: A Journal of Lesbian and Gay Studies* 19, no. 1 (January 1, 2013): 57–78. https://doi.org/10.1215/10642684-1729545.

Bränström, Richard, and John E. Pachankis. "Reduction in Mental Health Treatment Utilization among Transgender Individuals after Gender-Affirming Surgeries: A Total Population Study." *American Journal of Psychiatry* 177, no. 8 (August 1, 2020): 727–34. https://doi.org/10.1176/appi.ajp.2019.19010080.

Causadias, José M., Joseph A. Vitriol, and Annabelle L. Atkin. "Do We Overemphasize the Role of Culture in the Behavior of Racial/Ethnic Minorities? Evidence of a Cultural (Mis)Attribution Bias in American Psychology." *American Psychologist* 73, no. 3 (2018): 243–55. https://doi.org/10.1037/amp0000099.

Christian, Robin, Amy Anderson Mellies, Alison Grace Bui, Rita Lee, Leo Kattari, and Courtney Gray. "Measuring the Health of an Invisible Population: Lessons from the Colorado Transgender Health Survey." *Journal of General Internal Medicine* 33, no. 10 (2018): 1654–60. https://doi.org/10.1007/s11606-018-4450-6.

Edinburghath. “Edinburgh Action for Trans Health on Tumblr: Trans Health Manifesto.” Tumblr, July 28, 2017. https://edinburghath.tumblr.com/post/163521055802/trans-health-manifesto.

England, Evan Thomas, "Transgender Health: Exploring Medicalization and the Interactions of Race/Ethnicity, Disability, and Education" (2022). Master's Theses and Capstones. 1644. https://scholars.unh.edu/thesis/1644

Ferguson, Dana, Scott Maucione, Bente Birkeland, Rick Pluta, Colin Jackson, and Acacia Squires. “Minnesota to Join at Least 4 Other States in Protecting Transgender Care This Year.” NPR, April 21, 2023. https://www.npr.org/2023/04/21/1171069066/states-protect-transgender-affirming-care-minnesota-colorado-maryland-illinois.

Gill-Peterson, Julian. “Trans of Color Critique before Transsexuality.” *TSQ: Transgender Studies Quarterly* 5, no. 4 (November 1, 2018): 606–20. https://doi.org/10.1215/23289252-7090073.

Hanssmann, Christoph L. *Care without Pathology: How trans- health activists are changing medicine*. Minneapolis, MN: University of Minnesota Press, 2023.

Johnk, Lzz, and Sasha A. Khan. "‘Cripping the Fuck Out:’A Queer Crip Mad Manifesta Against the Medical Industrial Complex." Feral Feminisms 9 (2019): 27-38.

Keith, Katie. “Unpacking Colorado’s New Guidance on Transgender Health.” Commonwealth Fund, November 10, 2021. https://www.commonwealthfund.org/blog/2021/unpacking-colorados-new-guidance-transgender-health.

Law Week, By, and Law Week. “A Brief History of LGBT Rights in Colorado.” Law Week Colorado, June 10, 2021. https://www.lawweekcolorado.com/article/a-brief-history-of-lgbt-rights-in-colorado/.

Malatino, Hil. “The Promise of Repair: Trans Rage and the Limits of Feminist Coalition.” *Signs: Journal of Women in Culture and Society* 46, no. 4 (2021): 827–51. https://doi.org/10.1086/713292.

Malatino, Hil. *Trans care*. University of Minnesota Press, 2020.

Meyers, Quincy. “Strange Tensions.” *TSQ: Transgender Studies Quarterly* 9, no. 2 (May 1, 2022): 199–210. https://doi.org/10.1215/23289252-9612851.

Mingus, Mia. “Medical Industrial Complex Visual.” Leaving Evidence, September 12, 2018. https://leavingevidence.wordpress.com/2015/02/06/medical-industrial-complex-visual/.

Minich, Julie Avril. “Enabling Whom? Critical Disability Studies Now.” *Lateral* 5, no. 1 (May 2016). https://doi.org/10.25158/l5.1.9.

navidson, soma. “Unlearning: Improving Trans Care by Reorienting Medical and Nursing Discourse.” Essay. In *The Remedy: Queer and Trans Voices on Health Care*, 31–39. Vancouver: Arsenal Pulp, 2016.

Peeples, Jase. “GLAAD Urges N.Y. Gov. to Help Trans New Yorkers Get Needed Health Care.” Advocate.com, November 17, 2015. https://www.advocate.com/politics/transgender/2013/11/15/glaad-urges-ny-gov-help-trans-new-yorkers-get-needed-health-care.

Piepzna-Samarasinha, Leah Lakshmi. 2019. “Care Webs,” in Care Work: Dreaming Disability Justice. Third printing ed. Vancouver, BC: Arsenal Pulp Press. http://bvbr.bib-bvb.de:8991/F?func=service&doc_library=BVB01&local_base=BVB01&doc_number=031725187&sequence=000001&line_number=0001&func_code=DB_RECORDS&service_type=MEDIA.

Puar, Jasbir K. “Bodies with New Organs.” *Social Text* 33, no. 3 (September 1, 2015): 45–73. https://doi.org/10.1215/01642472-3125698.

Raha, Nat. “Embodying Autonomous Trans Health Care in Zines.” *TSQ: Transgender Studies Quarterly* 8, no. 2 (May 1, 2021): 188–98. https://doi.org/10.1215/23289252-8890565.

Reynolds, Megan M. “Health Power Resources Theory: A Relational Approach to the Study of Health Inequalities.” *Journal of Health and Social Behavior* 62, no. 4 (November 30, 2021): 493–511. https://doi.org/10.1177/00221465211025963.

Schalk, Sami. 2017. "Critical Disability Studies as Methodology." Lateral 6 (1). doi:10.25158/L6.1.13. https://explore.openaire.eu/search/publication?articleId=doajarticles::a1ec264ffbd4f728b0a75c79c35c6c3a.

Seelman, Kristie L., Sarah R. Young, Megan Tesene, Luis R. Alvarez-Hernandez, and Leo Kattari. “A Comparison of Health Disparities among Transgender Adults in Colorado (USA) by Race and Income.” *International Journal of Transgenderism* 18, no. 2 (2016): 199–214. https://doi.org/10.1080/15532739.2016.1252300.

Sharman, Zena. Essay. In *The System Isn’t Broken, It’s Working as Designed*. Vancouver, BC: Arsenal Pulp Press, 2021.

Sharman, Zena. *The care we dream of: Liberatory & transformative approaches to LGBTQ+ health*. Vancouver: Arsenal Pulp Press, 2021.

Snorton, C. Riley. *Black on both sides: A racial history of trans identity*. Minneapolis, MN: University of Minnesota Press, 2017.

Williams, D R, and T D Rucker. “Understanding and Addressing Racial Disparities in Health Care.” Health care financing review, 2000. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194634/.

Winter, Sam, Edmund Settle, Kevan Wylie, Sari Reisner, Mauro Cabral, Gail Knudson, and Stefan Baral. “Synergies in Health and Human Rights: A Call to Action to Improve Transgender Health.” *The Lancet* 388, no. 10042 (July 2016): 318–21. https://doi.org/10.1016/s0140-6736(16)30653-5.

Wolff, Michelle, David A. Rubin, and Amanda Lock Swarr. “The Intersex Issue.” *TSQ: Transgender Studies Quarterly* 9, no. 2 (May 1, 2022): 143–59. https://doi.org/10.1215/23289252-9612767.

Appendix

Resources- Navigating Trans Care in Colorado (As of April 28, 2024)

Colorado Crisis Services: 1-844-493-8255 | Text "TALK" TO 38255

COLORADO SPRINGS

Medical Care

- Courtney Crance, DO (HRT, PCP) (Colorado Springs)
- Dr. Erika Overbeek-Wager, DO (Colorado Springs)
- Syretta McGraw, (Psychiatric Nurse Practitioner, MSN, APRN, PMHNP) (Colorado Springs)
- Christopher Neal Wade II (LPC, NCC) (Colorado Springs)
- UCHealth ER
- Dr. Deborah Tuffield, (DNP, FNP-C)
- UCHealth (*longer wait times*)
- Dr. Dan Johnson, PhD
- Dr. Swosti Roka Magar, MD (Rheumatologist)
- Dr. Laura L. Longwell, DO (PCP)
- Dr. Tessa Lowenstein (Chiropractor) (Colorado Springs)
- Powers Dental (Colorado Springs)

Community Resources

- Sunday Barber Co. (Colorado Springs) (Barber Shop/Hair Stylist)
- Community (A Walgreens Pharmacy) (Colorado Springs)
- Inside Out (Colorado Springs)
    - LGBTQ+ Resource Center for youth ages 13-23

- Rainbow Connection Colorado (via Meetup)
- Colorado Springs Prism Community Collective
    - Physical space is opening soon, but has a directory of mental & physical health providers

DENVER AREA

- Jarom Gilstrap (surgeon) (Denver)
- Kaiser Trans Healthcare Unit
- Denver Health
- Dr. Mia Scott (PCP) (*HIV+ clinic only*)
- Katherine B Weber (endocrinologist - *fine but not great*) (Aurora)

Community Resources

- The Center on Colfax (Denver)
    - LGBTQ Center with weekly support groups (in-person & online)

UNITED STATES-WIDE

- PFLAG
    - Nation's largest organization dedicated to supporting, educating, and advocating for LGBTQ+ people

ONLINE

- Plume (Online HRT)
- Folx Health (Online HRT - increasingly expensive but takes insurance and is on a pay-for-service basis)
- Susan’s Place (Old-school text forum for creating friendships)

- Meetup (Various groups across the country, highlights queer spaces and meetups in various cities)
- Undead Voice Training (and YouTube video tutorials)
- Trans Voice Lessons (free and paid options for vocal training)
- Facebook Groups (area-specific, but most cities have queer Facebook groups for varying resources and support)

GENERAL RESOURCES FOR GENDER-AFFIRMING CARE

- OutCare Health - LGBTQ+ Healthcare Resources & Providers
- Erin’s Informed Consent HRT Map of the U.S.
- Planned Parenthood