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Qualitative Analysis of Transgender Inmates' Correspondence: Implications for Departments of Correction

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Abstract

Claims of inadequate health care and safety afforded to transgender inmates have become the subject of litigation. This article reviews 129 unsolicited letters from transgender inmates writing from 24 states and the Federal Bureau of Prisons to identify their concerns. Among the letters reviewed were reports from 10 inmates who had filed lawsuits naming departments of correction (DOCs) as defendants, claiming inadequate access to transgender health care. Five of these lawsuits have gone to trial. In all of those cases, the defendant settled the matter or was found liable as of the time of this report. Claims of inadequate care for transgendered patients that have sufficient merit to be fully litigated in U.S. courts appear likely to produce verdicts in favor of plaintiff inmates. The information gleaned from reviewing letters from transgendered inmates may alert staffs of DOCs to concerns worth addressing proactively to avoid the costs associated with transgender-related lawsuits.

Keywords

prison, transgender, policies, transsexual, gender identity

Introduction

Inmates who experience a substantial and disturbing sense of incongruity between their anatomical/birth sex (visible genitals) and their "felt" (subjective) masculine or feminine self meet the criteria for the psychiatric diagnoses described in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; 4th edition, text revision) as gender identity disorder (GID) or gender identity disorder "not otherwise specified" (American Psychiatric Association, 2000; see also Brown, 2001).

With the publication of DSM-5 in May 2013, the diagnosis of GID is changed to gender dysphoria (GD) in recognition of the fact that those with this condition do not suffer from a disordered identity but rather from a constellation of symptoms that are both recognizable and treatable (American Psychiatric Association, 2013). This article describes the prison population at issue using the nomenclature most familiar during the past decades—"transgender" or "gender dysphoria."

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The vast majority of transgender inmates have a male birth sex and retain male genital anatomy as opposed to the far smaller number of inmates born female who feel their true self is masculine. A significant number of inmates undergo treatment for GID prior to incarceration, including cross-sex hormones and/or sex reassignment surgery (SRS). A very few, but alarming number of, inmates will have tried to treat their transgender condition with surgical self-treatments (Brown, 2010).

Inmates with transgender identification pose special challenges in a corrections environment, including safety considerations; predatory behavior by other inmates; rules infractions regarding clothing, hair, and makeup; and health care considerations unique to this population (Brown & McDuffie, 2009). Thus, departments of correction (DOCs) need health care providers with training and expertise to treat GID/GD inmates not ordinarily encountered among most primary care providers in the free world.

The stakes in delivering adequate and appropriate medical care to GID patients is high. Transgender inmates suffer inordinately from mental health problems, such as depression and suicidality (Coleman et al., 2012), and have resorted to autocastration and autopenectomy in some cases (Brown, 2010). Thus, inadequate medical care for the transgender inmate may lead to extraordinary expenditures for emergency medical and psychiatric care.

Institutions that fail to take seriously the specialized needs of transgender inmates may also face legal liability for violation of the inmates' Eighth Amendment rights (*Gammett v. Idaho Department of Corrections*, 2007).

The number of transgender inmates with GID is not large in absolute numbers. The nationwide estimate in both state and federal institutions combined as of 2010 was less than 1,000 (Brown, 2010). However, their medical and custodial needs are substantial. Transgender inmates present institutions with significant medical care and housing concerns that are out of proportion to their small numbers in institutions that, by their very nature, are inflexible in dealing with the sex and gender of inmates under their supervision. Blight (2000, p. 6) noted:

> Transgender inmates present a unique set of issues that, if not appropriately dealt with, could lead to a greatly increased incidence of assault and self-harm in that population. Failure to implement appropriate policies may also amount to a breach of antidiscrimination legislation and/or human rights obligations.

Although individual transgender inmates' situations and requests for services are recorded in court documents (e.g., *Gammett v. Idaho Department of Corrections*, 2007; *Kosilek v. Maloney*, 2002; *Kosilek v. Spencer*, 2012), little is known about the range of concerns of transgender inmates across the country. This study addresses that void by documenting the concerns of 129 inmates from prisons in all regions of the United States.

Methods

This study was cleared by the East Tennessee State University Institutional Review Board. The Gender Identity Center of Colorado has supported a free prison outreach effort in the form of the *TIP Journal* (Trans in Prison) for many years. The journal is mailed to prisoners throughout the United States who self-identify as transgender and who wish to be on the mailing list. Inmates often write unsolicited letters to the editor of the journal. The previous editor of the *TIP Journal* (Maddie Madison) preserved those letters and often responded to them as a service to incarcerated transgender inmates. The initial letters from inmates over approximately a 3-year time frame were redacted by the editor for personally identifiable information and sent to the author for analysis. A review of these letters identified numerous themes falling into one or more of 20 distinct categories. These categories were grouped by major theme; for example, the content categories "access to evaluation for gender identity disorder," "access to cross-sex hormones," "access to sex reassignment

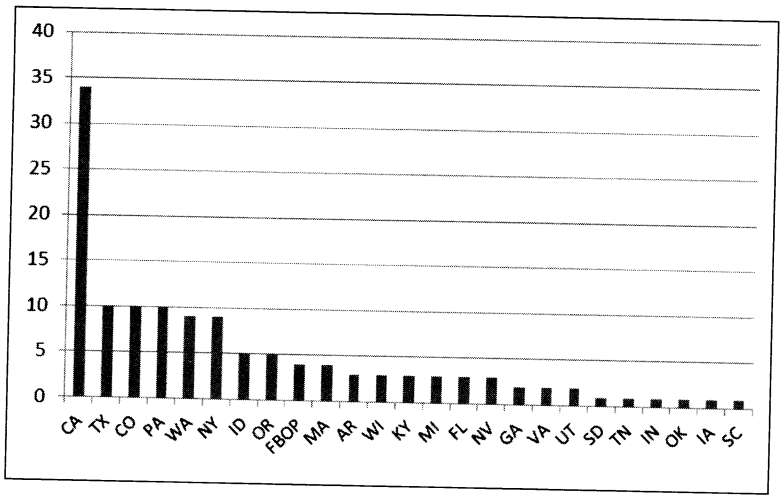

Figure 1. Responses by state ($N = 129$).

surgery," and "access to electrolysis" were aggregated into the major category of "access to transgender health care." Letters that were simply asking for a subscription to the *TIP Journal* were not included in this analysis. As these letters were unsolicited, no survey instruments were utilized.

Results

Letters from 129 inmates were reviewed for thematic content. All letters were from inmates currently serving sentences in 1 of the 24 state DOCs or the Federal Bureau of Prisons (FBOP). No letters were submitted from anyone in other detention settings (e.g., Immigration and Customs Enforcement facilities, county jails, military brigs). Inmates identified themselves as male-to-female transsexual (48%), male-to-female transgender (49%), female-to-male transgender (< 1%), or intersex (2%). One inmate reported having had SRS. Cross-sex hormone use, current, was reported by 14% of inmates. No inmate reported being in a housing unit that was inconsistent with their genitalia. The distribution of responses by state is noted in Figure 1.

Six states accounted for the vast majority of submitted letters, with California prisoners submitting 26% of all letters analyzed. Although there was representation from DOCs in 24 states ($n = 125$) and the FBOP ($n = 4$), 50% of inmates were from 4 states (California, Texas, Colorado, and Pennsylvania). The letters' content themes fell into 10 major categories, with secondary themes in an additional 10 discrete categories. Number of themes per letter ranged between 1 and 5.

Figure 2 shows the distribution of the top 10 themes, with transgender health care issues accounting for the largest number (71; 55%) by a wide margin, followed by a variety of social issues and legal concerns. Examples of social issues included problems with family, conflicts with cellmates, lack of friends, and similar issues. Legal concerns generally included advice on how to access a pro bono attorney experienced with transgender inmates or help with a pending court case. Active symptoms or feelings of GD were specifically reported by 22% of the inmates. Although many writers discussed their wish to access transgender health care (including psychiatric evaluations, cross-sex hormonal treatments, SRS, access to female clothing and canteen items, and electrolysis), GD as an active symptom was not imputed from this information. Scoring for GD required that the letter has overt evidence of gender dysphoric symptoms. Abuse was reported by 42% of the inmates, with 23% reporting physical abuse or harassment and 19% relating that they had been sexually mistreated or abused by other inmates, corrections officers (COs), or both. Inmates alleged harassment by staff

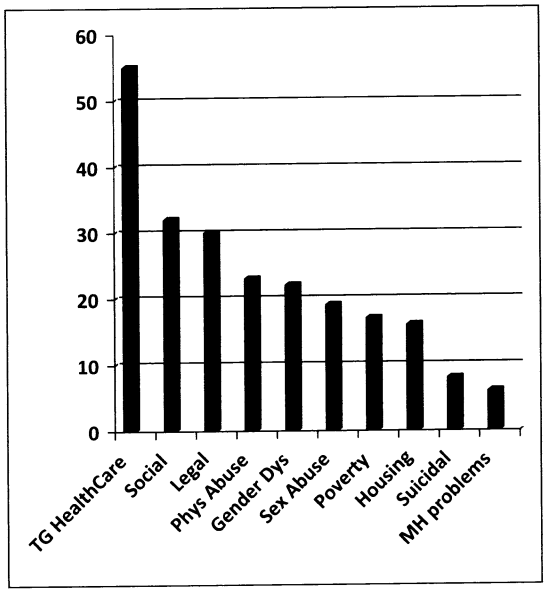

Figure 2. Top 10 concerns of transgender inmates (by percentage of responses).

related to their transgender status, for example, "The COs threatened me. Said they would smoke me out [of my cell], cut my balls and let me bleed then they would hang me." "[A CO] is condemning me and reprimanding me for being a transgender. Saying it was unnatural and that he would write me up for sexual misconduct if I continued to be this way."

Inmates also reported that engaging in behavior inconsistent with birth sex was sometimes met with hostility in the form of additional strip searches, with or without feeling that they were being groped in the process or other forms of reported retaliation, "I was charged with 'possessing escape paraphernalia,' which were homemade hair extensions" to cover male pattern baldness, using her own hair and weaving it in with dental floss colored with a marking pen.

Five percent of inmates reported that they had attempted (2%) or completed (3%) autocastration while incarcerated, "I performed self-castration upon myself. I resoned [*sic*] DOC refuses to treat my condition, and testicles produce testosterone and therefore, with no testicles, no testosterone." A second inmate wrote, "I castrated myself after giving up at the time on receiving treatment with hormones after many years." This inmate attached a copy of a DOC "Suicide Review Form" that had the following annotation by a CO at the scene, "This I/M has studied Gray's Anatomy for a long time and had probably planned the recent self-castration for a long time prior to engaging in the activity."

Discussion

Inmates diagnosed with GID or claiming to be transgendered seem to face peculiar challenges for the corrections environment that lead to a substantial amount of discord, complaints, and litigation. The most frequently reported problem mentioned by the inmates in this study is access to transgender health care, including evaluations for self-reported gender identity disturbances. The lack of access to a competent evaluation seems particularly troubling, as undiagnosed, and therefore untreated, GID/GD is known to be associated with significant morbidity and mortality (Brown, 2010; *Gammett v. Idaho Department of Corrections*, 2007). Moreover, it appears that the courts are recognizing GID/GD as a serious medical condition warranting treatment for the purposes of the Eighth Amendment (See *Adams v. Federal Bureau of Prisons*, 2010; *Cuoco v. Moritsugu*, 2000; *Kosilek v.*

Maloney, 2002; *Kosilek v. Spencer*, 2012; *Meriwether v. Faulkner*, 1987; *Phillips v. Michigan Department of Corrections*, 1990; *White v. Farrier*, 1988; *Wolfe v. Horn*, 2001).

DOCs have not adopted a uniform posture in favor of providing transgender health care (Brown & McDuffie, 2009). A number of states have refused to treat transgender patients with hormone therapy. A number of highly publicized lawsuits in the last 10 years have resulted in court orders that compelled prisons to allow the prescribing of hormones pursuant to physician recommendation. It seems well established that inmates with GID diagnoses are entitled to hormonal and other medical therapy when clinically indicated. But it remains disputed whether inmates with GID are properly treated by surgical reassignment of their sex while incarcerated (*Kosilek v. Spencer*, 2012).

In the first years of the 21st century, a majority of DOCs appeared to have not yet developed policies for treatment of GID or prohibited transgender health care (Brown & McDuffie, 2009). However, within the past few years, health care systems throughout the United States have more and more acknowledged the need for treating persons with GID in both the public and private sectors. In June 2011, the largest integrated health care system in the United States, the Veterans Health Administration (VHA), reversed its position on providing access to transgender health care for our nation's veterans by directing all VHA facilities to provide "respectful" transgender health care services to all transgender veterans, with the exception of SRS and electrolysis (Department of Veterans Affairs, 2011, 2013). The Patient Protection and Affordable Care Act (2010) also explicitly prohibits discrimination based on gender and gender identity.

Contemporaneously, the focus on equitable care and treatment for transgender persons became a focus of The Joint Commission, the accrediting body for hospital systems in both the public and private sectors. A 2010 monograph by this organization (The Joint Commission, 2010) contains several recommendations that can assist hospitals in meeting the needs of sexual and gender minorities, including a prohibition of discrimination based on sexual orientation and gender identity or expression. These requirements have been taken into consideration in the accreditation process since July 1, 2011 (The Joint Commission, 2011).

The California Department of Managed Health Care recently ordered all of California's privately insured health plans to remove blanket exclusions of coverage based on gender identity or gender expression in order to comply with the California Insurance Gender Nondiscrimination Act passed in 2005 (Barnhart, 2013). The letter to the insurers included the following direction to health insurers operating in the State of California:

> Ensure that individuals are not denied access to medically necessary care because of the individual's gender, gender identity, or gender expression; Revise all current health plan documents to remove benefit and coverage exclusions and limitations related to gender transition services; Revise all current health plan documents to remove benefit and coverage exclusions and limitations based upon an individual's gender, gender identity, or gender expression. (Barnhart, 2013)

While many of these national changes apply to a non corrections environment, courts have ruled similarly regarding access to medically necessary transgender health care in state DOCs, finding that GID is a "serious medical need" (*Fields v. Smith*, 2011; *Kosilek v. Maloney*, 2002) and that "adequate" medical care for the purposes of the Eighth Amendment includes access to appropriate evaluations for inmate-generated gender-related complaints and access to cross-sex hormones (*De'Lonta v. Angelone*, 2003; *Fields v. Smith*, 2011; *Kosilek v. Maloney*, 2002; *Phillips v. Michigan Department of Corrections*, 1990), female canteen items and clothing (*Kosilek v. Spencer*, 2012; *Tates v. Blanas*, 2003), and SRS when clinically indicated for an individual inmate (*De'Lonta v. Johnson*, 2013; *Kosilek v. Spencer*, 2012; *Soneeya v. Spencer,* 2012). The Internal Revenue Service recently lost a lawsuit over the deductibility of SRS as a medically necessary procedure, wherein the Federal Tax Court of Appeals ruled that SRS is medically necessary for some taxpayers, not

"cosmetic," and therefore constitutes a legitimate deductible medical expense (*O'Donnabhain v. Comm'r of Internal Revenue Service*, 2010).

California policies and procedures specifically provide medically appropriate psychiatric and medical care for transgender inmates, including access to specialized evaluations, cross-sex hormones, and female clothing items (*California Correctional Health Care Services Manual*, 2012).

The FBOP also revised its policies in 2010 and 2011 by issuing memoranda to FBOP chief executive officers that stated, in part:

> In summary, inmates in the custody of the Bureau with a possible diagnosis of GID will receive a current individualized assessment and evaluation. Treatment options will not be precluded solely due to level of services received, or lack of services, prior to incarceration.

The memo also states that "current, accepted standards of care will be used as a reference for developing the treatment plan."

The National Commission on Correctional Health Care issued a position statement titled Transgender Health Care in Correctional Settings (2009) that would seem to accommodate the prevailing court rulings that have ordered medical treatment for transgender inmates.

> The management of medical (e.g., medically necessary hormone treatment) and surgical (e.g., genital reconstruction) transgender issues should follow accepted standards developed by professionals with expertise in transgender health. Determination of treatment necessary for transgender patients should be on a case-by-case basis. Ideally, correctional health staff should be trained in transgender health care issues. Alternatively, they should have access to other professionals with expertise in transgender health care to help determine appropriate management and provide training in transgender issues.

And:

> Because inmate-patients may be under different stages of care prior to incarceration, there should be no blanket administrative or other policies that restrict specific medical treatments for transgender people. Policies that make treatments available only to those who received them prior to incarceration or that limit GID treatment to psychotherapy should be avoided.

Sexual abuse and physical abuse were frequently reported in the letters from transgender inmates that were reviewed for this study. Jenness (2009) similarly reported this in a large study of California transgender inmates where these inmates were 13 times more likely to suffer sexual assault/rape than non-transgender-identified inmates. Nuttbrock and colleagues (2010) described the serious psychiatric sequelae of abuse as experienced by transgender persons. The Prison Rape Elimination Act (PREA; 2003) specifically mentions sexual and gender minorities, to include transgender inmates, as vulnerable populations that warrant additional attention by corrections staff. While inmate allegations of corrections staff engaging in abusive behavior may be viewed cynically, the reprehensible behavior has been proven to have occurred. In *Schwenk v. Hartford* (2000), for example, a court ruled in favor of a transgender woman in prison who claimed a guard grinded his exposed penis into her buttocks after she refused his demand for oral sex, allowing her to make an Eighth Amendment argument against the DOC.

A particularly horrible complication of GID is attempted autocastration. Autocastration in prison settings is most often associated with a primary diagnosis of GID that is untreated or undertreated, with numerous examples of such behaviors occurring in corrections facilities in multiple countries (Blight, 2000; Brown, 2010; Conacher & Węstwood, 1987; More, 1996). Five percent ($n = 6$) of the inmates writings reviewed in this survey reported attempted or completed autocastration while

incarcerated. Autocastration attempts obviously expose the DOC to substantial medical costs and litigation that detracts from important DOC missions (*Gammett v. Idaho Department of Corrections*, 2007; *Kosilek v. Maloney*, 2002; *Kosilek v. Spencer*, 2012).

Suicidality was reported by 8% of those who submitted letters, including both past attempts and current thoughts of harming themselves. These feelings were often linked in the letters to gender dysphoric feelings or frustrations over not receiving access to transgender health care. This percentage is markedly lower than that reported in the literature for transgender populations in the community (41% reported lifetime suicide attempt rate; Grant et al., 2011) or in the Department of Veterans Affairs (20 times higher than non-transgender veterans; Blosnich et al., 2013). This may be accounted for by the fact that other studies of suicidality in transgender populations asked specific questions about suicidal thoughts and behaviors, whereas this naturalistic study could not do so. In any event, 8% spontaneous reporting of suicidal ideation and behavior is substantial and appears to be linked, at least in the letter writer's mind, to GD symptoms and lack of treatment.

Limitations of the Study

This study has several important limitations. Since it was a naturalistic, observational study of unsolicited letters, no survey instruments or structured questions could be utilized. Therefore, percentages of inmates who reported particular content areas (e.g., suicidality, autocastration attempts, and physical and sexual abuse) would likely be different had the inmates been specifically asked about their experiences in a structured manner. Self-reports could not be verified independently, which has implications for content areas such as allegations of sexual and physical abuse and suicidal behaviors. Finally, although nearly half of the states were represented by one or more inmates' letter/letters, this sample of convenience may not be representative of the experience of transgender inmates in other prisons, in other states, or nationally. In essence, the letters received could constitute an enriched sample of those transgender inmates who are having problems in their particular prison setting and may be unrepresentative of those transgender inmates who do not write letters. It should be noted, however, that many of the issues reported by the 129 inmates in this study do reflect the publicly available record of litigation by transgender inmates against DOCs, in particular on the issues of lack of access to transgender health care, autocastration, physical and sexual abuse, and suicidality (Brown, 2009, 2010).

Conclusion

In the modern view of medical experts and U.S. courts, GID is a disease deserving treatment. A review of 129 unsolicited letters described, nevertheless, a great many cases where inmates alleged inadequate treatment for their transgender condition. The allegations contained in this report were not investigated or validated as true, nor are the letter writers necessarily representative of all transgendered patients. But the number of complaints about this matter is sufficient, even without validation of the letter contents, for further consideration.

The right of transgender inmates to receive medical treatment is no longer in doubt. Thus, complaints about nontreatment of GID deserved as much consideration as the complaint that diabetes or heart disease is not treated. DOCs have started to adopt proactive policies to reflect the advances in diagnosis and treatments for GID that have occurred in the past decades. Such policies are likely to reduce the risk of adverse clinical outcomes in these patients and also should reduce the amount and cost of litigation that might otherwise be generated by transgender inmates denied medical treatments for their condition. DOCs can find some of the current standards for care of transgender patients in guidelines published by the World Professional Association for Transgender Health in the *International Journal of Transgenderism* (Coleman et al., 2012).

The reports of physical and sexual abuse are also cause for concern, given that transgender inmates are known to be in a vulnerable subpopulation as defined by PREA. Suicidality appears to be linked to symptoms of GD and lack of adequate, or indeed any, treatment for these symptoms.

The issue of how to best treat transgender inmates or inmates with the diagnosis of GID is likely to remain very controversial for many years. But the matter cannot be ignored. Future directions in understanding the issues faced by transgender inmates and the implications for DOC administrative and medical policies may benefit from a formal survey of the diagnosis and treatment of transgender inmates nationwide.

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Author's Note

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