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Gender Identity: Pending? Identity Development and Health Care Experiences of
Transmasculine/Genderqueer Identified Individuals

By

Sarah L. Schulz

A dissertation submitted in partial satisfaction of the

requirements for the degree of

Doctor of Philosophy

in

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in the

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of the

University of California, Berkeley

Committee in charge:

Professor Eileen Gambrill, Chair
Professor Lorraine Midanik
Professor Kristin Luker

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Abstract

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The purpose of this study was to explore the identity development process and health care experiences of individuals who identify their gender somewhere along the transmasculine spectrum. Historically, researchers and clinicians have viewed the transgender experience through a lens of medical pathologization and have neglected to acknowledge the diverse experiences of those who identify as transmasculine. The current standards of care for accessing transition-related health services require transmasculine individuals to express a narrative of distress in order to gain access to services, which further pathologizes those with complex identities that transcend the traditional categories of "male" and "female".

Using a qualitative grounded theory approach, data were collected through semi-structured interviews with 28 transmasculine identified individuals. Additionally, results from a pilot study with 15 genderqueer identified individuals supplemented these interview data.   The interviews focused on the process of transmasculine identity development and experiences in seeking and receiving health care services across a variety of practice settings. Participants also shared how their interactions with individual health and mental health care providers, organizations, and the larger managed care system impacted (both positively and negatively) their experiences of gender identity development.

A number of themes associated with transmasculine identity development were identified. An analysis of these themes revealed that transmasculine identity development is inadequately classified using the DSM model of Gender Identity Disorder. Instead of viewing transmasculine identity as an individual, disordered experience of identity, it is important to incorporate the personal, social, and cultural factors that influence transmasculine identity development. Shifting the focus from viewing transmasculinity solely as an individual problem or disorder may move us closer to the goal of replacing the pathology model with an identity-affirming model of transmasculinity.

The results of this research also indicate that various components of health care provision may impact transmasculine identity development. Access to trans-friendly health care organizations and providers, an informed consent model of health care provision, trans-friendly organizational policies, insurance coverage for transgender health needs, and relationship-centered communication with health providers all lend themselves to a positive, affirming experience of identity.

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This dissertation is dedicated to Isaac, for inspiring me to make the world a better place in which to live and grow.

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Chapter 1: Statement of Research Problem

Over the past decade, a growing body of literature has documented the medical, mental health, and psychosocial needs of members of the transgender community. However, much of the existing research focuses on transgender women, or, individuals who were assigned male at birth but who transition to female through the use of hormonal and/or surgical interventions. Much less attention has been given to the unique needs, experiences, and barriers to accessing social services that are faced by individuals who identify on the transmasculine spectrum.

The *transmasculine* community consists of individuals who were assigned or announced as female at birth but who identify their gender with a prominent masculine component (Green & Peterson, 2006). This includes a diverse spectrum of identities ranging from "butch" (masculine) lesbians who forego medical intervention, to individuals who medically and legally transition and live full-time as male. Many transmasculine individuals are comfortable living between gender categories and may not desire to medically change their bodies; still others may choose to alter their gendered appearance through hormonal treatment and/or traditionally gendered clothing but do not desire full surgical intervention or legal gender transition (Lev, 2004). Others in the transmasculine community may identify as "genderqueer", which could mean having no gender identity, identifying as both male and female, or identifying with a gender that exists completely outside of the "male/female" binary (Nestle, Howell, & Wilchins, 2002; Forshee, 2008).

Historically, much of the existing research on this topic has viewed the transgender experience through a pathologizing lens, and practitioners have labeled those who do not fit normative categories of gender as mentally ill. Also, a majority of the literature from the psychological and medical fields focuses on transpeople who wish to alter their physical bodies through hormonal treatments or gender reassignment surgery, or who live full-time and/or "pass" in the gender identity which is opposite of the biological sex that that they were assigned at birth. However, this perspective fails to acknowledge the multitude of identities within the transgender community, including the complex identities that transcend the traditional categories of "male" and "female".

Gender transition is a lengthy, costly, and often non-linear process, and there are many ways that individuals choose to undergo transition. Despite the diverse range of transgender identities, social service providers and medical professionals and systems have played an important role in transmasculine identity development by enforcing the binary gender system and requiring individuals with non-binary identities to identify as "male" or "female" in order to be granted access to medical assistance related to the transition (Califia, 1997, Cromwell 1999). Transpeople are often encouraged to not disclose a non-binary identity in order to "justify" the need for transition (Green, 2004). As a result, many transmasculine individuals do not "come out" to their health providers as transgender, or will mask non-binary identities to fit into mainstream gender categories in order to gain necessary health services. Conversely, providers who take a "trans-affirming" approach to mental health and medical treatment may contribute to a positive experience of transmasculine identity and positive self-image.

Although there are numerous barriers to accessing medical and mental health services, individuals in the transmasculine community have unique health and mental health concerns (Clements-Nolle et.al, 2001; Grossman & D'Augelli, 2007; Kenagy, 2005). While some transmasculine individuals enter into the health care system specifically seeking hormone and surgical interventions related to gender transition, others are in need of routine/primary health care services.

Those with limited economic resources or who are reluctant to use their health insurance due to the complicated nature of the healthcare system must rely on the public mental health, healthcare, and social welfare systems to meet their needs, where they often face many barriers to accessing the services that they require. These barriers include system-related barriers, such as discriminatory agency-based and managed care policies, and provider-related barriers, such as lack of education and training about transgender healthcare needs. Although the barriers to accessing services for this community are well-documented, there is a dearth of information regarding how individuals seek and receive healthcare services, and the degree to which interactions with medical and mental health providers impact identity development.

Key Terminology

In order to understand the social welfare, mental health, and healthcare needs of gender variant individuals, it is important to first review key concepts from within the field of gender studies. *Gender* is defined as an individual's "self-identity and/or social representation" as male or female (Torgrimson & Minson, 2005). It is a complicated phenomenon where biological and psychological components of identity intersect with the social construction of culture (Lev, 2004). *Gender identity* is an individual's emotional and physiological sense of self-identification as male or female (Wilson & Reiner, 1998). *Biological sex (*or commonly, just *sex*) refers to a complex relationship of genetic, hormonal, and anatomical determinates that impact both the physical body and the sexual differentiation of the brain (Lev, 2004). Mainstream biological sex categories include natal males and natal females, although *intersex* individuals may have genetic, hormonal, and anatomical characteristics of both males and females. In most non-transgender individuals, biological sex is compatible with the gender identity and *gender role,* which has been defined as a set of behaviors, attitudes, and personality traits which are culturally constructed and attributed to, expected from, or preferred by persons of one gender category or the other (Cohen-Kettenis & Gooren, 1999).

Transgender individuals, or transpeople, challenge the idea that an individual's assigned birth sex predicts what their gender identity will be. *Transgender* is an umbrella term used to describe many categories of people who are gender variant, and the term "trans" is sometimes used as a descriptor to refer to the community as a whole. The term *transsexual* has commonly been used to describe transgender individuals who live fully in the gender category that is opposite of their biological sex, but not every transperson espouses an "opposite sex" identity. *Transgender men* , (often referred to as transmasculine, Female-to-Male, FTM, or transmen), were assigned female at birth but identify as male/masculine, while *transgender women*, (also referred to as transfeminine, Male-to-Female, MTF, or transwomen) were assigned male at birth and identify as female/feminine.

While some transpeople identify with a binary gender category (i.e., male or female), transgender identities do not always reflect mainstream gender options: there is a diverse experience of non-normative gender and variance across the community. For example, some gender variant individuals identify as *genderqueer*, which could mean that they identify as both male and female, neither, or somewhere in between (Nestle, Howell, & Wilchins, 2002). The diversity of the transgender community highlights that there is a wide spectrum of gender identities, and that some transpeople transcend the categories of male and female completely. Bockting (2008) asked transgender respondents (n=1,229) how they describe their gender identities, and the diverse responses included non-binary gender options such as bi-gender, gender neutral, 3rd gender, polygendered, and gender fluid. Notably absent from these gender descriptions are the words "male" and "female", suggesting that some transgender people identify with gender categories outside of the binary categories of male

and female.

Gender identity differs from *sexual identity,* which is an overarching term describing an individual's sense of their own sexuality, and includes the relationship between biological sex, gender identity, gender expression, and sexual orientation (Lev, 2004). *Sexual orientation*, in contrast to gender identity, describes who an individual is attracted to emotionally, sexually, or romantically. Transgender individuals, like all individuals, may identify their sexual orientation as heterosexual, homosexual, bisexual, asexual, or pan/polysexual. Another general identity category that some individuals may use to describe their sexual identity is simply "queer".

Some transgender individuals who desire to alter their physical bodies undergo *"transition"*, which is generally a term used to describe the process that an individual moves through to have their physical body and/or legal status align with their gender identity. While some individuals may medically transition through the use of hormones and/or surgeries, other individuals consider themselves 'in transition' while they explore the physical, legal, and psychological, and social implications of moving from one gender category to another.

The surgical process involved in changing from one gender category to another has been referred to as "gender reassignment surgery" (GRS) or "sexual reassignment surgery" (SRS), although other researchers have described gender-related surgical interventions as "Gender Confirmation Surgery" (Sevelius, 2009). It is important to note that not all transgender individuals desire or have access to full surgical intervention, and referring to a transperson by medical intervention status (i.e., "pre-op" or "post-op") is in many cases inappropriate. Finally, while it is difficult to remove all generalizations when describing the health, mental health and social welfare needs of marginalized groups, it is important to be particularly mindful that the transgender/gender variant community is diverse and there is not one way to experience or undergo transition.

Background and Significance

Prevalence of Gender Variance and Gender Identity Disorder

Estimation of the prevalence of gender variance is based on a complex nexus of factors including medical technology, individual and social customs, the availability of services, and changing standards of care for the treatment of gender variance (Olyslager & Conway, 2007). Currently, there are limited data capturing the prevalence of transgender identity in the United States, and there have been no formal epidemiological studies focusing on the prevalence of gender variance. In a review of existing articles addressing the prevalence of transgender identity, Olyslager & Conway (2007) re-calculated the prevalence of those who seek gender reassignment through gender clinics in Sweden, the Netherlands, and various other European countries. Based on existing incidence data of those who have undergone gender confirmation surgery and taking into account birth, reassignment, and death rates, the authors estimated the latent and inherent numbers of people who will at some point undergo gender confirmation surgery. They determined that the prevalence of those who desire to change their gender from one gender category to another is likely to be between 1:1000 and 1:2000; the estimate of those who fall under the transgender umbrella is likely to be at least 1:100, or 1% of the population. This is significantly greater than the estimates used by the psychiatric community, which indicate that the prevalence of Gender Identity Disorder is 1:30,000 natal males and 1:100,000 natal females (American Psychiatric Association, 2000). The existing studies also consistently highlight that the

prevalence of transsexualism in male-to-female individuals is greater than in those transitioning from female to male, although it has also been suggested that the reason for this is that gender variance among biological females tends to be relatively invisible, particularly to mental health professionals and researchers (Meyer, et al., 2001). This is because transgender men may more easily "pass" in their preferred gender category with and without seeking hormonal or surgical intervention, while transgender women may have a greater difficulty doing so.

Based on studies from non-US samples where there are national data available, there appears to be a growing number of transpeople who are seeking medical intervention (Hoenig & Kenna, 1974; Scottish Needs Assessment Programme, 2001; Tsoi, 1988). The existing data indicate an upward trend of those seeking treatment for gender identity concerns. However, most of the studies rely on clinical data or data from people who are "out" as transgender or transsexual and who were actively seeking services. These studies do not account for transpeople who have not yet sought treatment, who do not opt for hormonal and/or surgical intervention, or those who lack access to gender services. Also, many of the prevalence studies rely on clinical diagnosis of gender identity disorder, or rely on other less rigorous methods, such as parental endorsement on questionnaires (Zucker & Lawrence, 2009). Calculating the prevalence of transgender identity is also complicated given that identities, particularly gender identities, may be viewed as in-flux, ever changing, and in some individuals, fluid; this is not acknowledged by existing methodologies.

The number of transgender individuals who seek medical intervention is a small percentage of individuals in the larger transgender community, and the number of transpeople who identify somewhere on the transgender spectrum is likely significantly higher than those reflected in the existing studies. In response to the need for more consistent and accurate data on the number of transgender individuals in the population, researchers from the Center of Excellence for Transgender HIV Prevention (Sausa, Sevelius, Keatley, Iñiguez, & Reyes, 2009) call for "trans-inclusive data collection", and recommend that health and social services agencies ask clients and research participants for information on both their current gender identity as well as their assigned sex at birth.

Gender Identity Disorder: A Contested Diagnosis

Although approaches to working with transgender individuals vary, many mental health and healthcare providers assume that gender variance is a mental health disorder and is rooted in inherent psychopathology (Bilodeau & Renn, 2005). The medical model of gender variance is the dominant lens through which transgender identity is viewed in psychiatric and psychological discourses today. This model relies heavily on the concept of "normal" gender development and the notion that those who fall outside of the binary gender system are mentally ill and in need of treatment. Gender identity disorder, or GID, is the current psychiatric diagnosis used by clinicians to diagnose individuals who are gender variant. The diagnosis of GID was first introduced into the DSM-III in 1980. It was first established as two separate diagnoses: "Transexualism" for adults and adolescents, and "Gender Identity Disorder of Childhood" for children with non-normative gender presentation (Zucker & Spitzer, 2005). The diagnosis was further revised for inclusion in the DSM-IV, with the subsequent removal of "transexualism" and a shift toward using "Gender Identity Disorder" with different criteria subsets for children and adults (APA, 2000).

There are currently four main criteria for a diagnosis of gender identity disorder in adults, and these include a) a strong and persistent cross-gender identification, which is defined as the desire to be, or the

insistence one is, the other sex; b) persistent discomfort with one's assigned sex or a sense of inappropriateness in the gender role of that sex, and c) the condition must not be a part of a physical intersex condition, and d) there must be evidence of clinically significant distress or impairment in functioning (APA, 2000). The current diagnostic criteria also include specifiers for whether the individual is sexually attracted to males, females, both, or neither. Proponents of maintaining GID as a mental health diagnosis assert that a diagnosis is necessary to guide treatment decisions and research protocols for transgender individuals, and to determine if an individual has satisfied the standard of care requirements necessary to be eligible for gender transition services (Lev, 2004). Further, proponents for the diagnosis suggest that it is necessary when seeking reimbursement from insurance companies to have a diagnosis justifying the medical interventions.

One of the frequently cited critiques of the inclusion of GID in the DSM is that the diagnosis was entered into the DSM specifically following the removal of homosexuality as a way for the profession of psychiatry to continue to pathologize non-normative sex and gender experiences (Bem, 1993; Isay, 1997). Although this explicit link has been disputed elsewhere (see Zucker and Spitzer, 2005), the validity of the diagnosis of GID remains questionable. The diagnosis of homosexuality was removed in response to political pressure and "expert consensus" within the APA, as opposed to being based on rigorous scientific evidence. Also, unlike gender identity disorder, homosexuality does not require medical intervention, while some individuals with non-normative gender presentation and gender dysphoria *do* require hormonal and surgical intervention (Bockting, 2009). Therefore, while it is important to acknowledge the historical context of the inclusion of the diagnosis in comparison to homosexuality, it is also important to avoid oversimplification of the need to remove the diagnosis of GID from the DSM completely without offering viable diagnostic alternatives. For example, proponents of the removal of GID from the DSM suggest that using the diagnosis of transexualism (which is included as a medical diagnosis in the International Classification of Diseases (ICD)) would remove the stigma of a mental disorder while maintaining the requirement that a medical diagnosis be used to determine eligibility for surgical intervention.

Critics of the inclusion of GID in the DSM also question whether the diagnosis applies to *both* gender dysphoria (discomfort in one's gender category) and gender non-conformity. The diagnosis solely acknowledges individuals who espouse a mainstream binary gender identity of "male" or "female", and assumes that there are certain appropriate ways to be male or female that are fixed and inherent. For example, the APA describes diagnostic features for gender identity in boys to include "preoccupation with traditionally feminine activities", such as playing with Barbies and avoiding "rough and tumble play"; girls with GID display intense reactions to "dresses and other feminine attire" and prefer "batman or superman" (APA, 2000). It can be argued that the gendered nature of clothing and toys is culturally driven, not inherent, and that children with gender variant behaviors may be experiencing distress in relation to parental and societal pressure to conform to their "appropriate" gender category. Further, The DSM diagnosis acknowledges only the binary experience of gender, which reinforces the cultural norms that privilege some gender identities over others.

There is also concern about whether the impairment in functioning is secondary to inherent clinically significant distress, or social stigma and discrimination resulting from the expression of a non-normative gender identity. The assumption that there are only two genders that are biologically determined not only pathologizes those with non-normative gender identities and experiences, but it devalues the possibility that those who experience distress in important areas of functioning may do so not because of an underlying psychological impairment, but due to society's response to non-normative

gender presentation (Lev, 2004). The pejorative language implies that an individual's identity is disordered, instead of examining and challenging society's notions that there are appropriate ways to be male and female.

The GID debate has also centered around the etiology of gender identity disorder and critics of inclusion of the disorder in the DSM have argued that if GID is a desire to change the physical body to align with innate sense of gender, it should be classified as a medical disorder, as in the ICD. One group advocates for the removal of GID from the DSM and the creation of a medical diagnosis, "Harry Benjamin Syndrome" (HBS), named for the German endocrinologist whose work focused on the biological basis for transsexualism (Goiar, 2012). HBS proponents assert that GID as a mental health diagnosis is pathologizing and that those with gender dysphoria have a bio-medical condition in need of medical, not mental health intervention. HBS proponents suggest that the condition has nothing to do with identity, and they strongly reject the idea that gender is a continuum and "are not seeking to defy social norms, as is the case of transgender" (Goiar, 2012). This privileging of binary identities over non-normative ones may divide the trans rights cause by making those with "true transsexualism" more valid than those who take a non-traditional gender transition trajectory.

Gender Incongruence

In response to the various critiques, the DSM-IV criteria for GID are currently under revision by the APA task force for the DSM-V, which is scheduled for publication in 2013. The proposed change of the diagnosis would rename the disorder "Gender Incongruence", which is defined as a marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration. In order to qualify for the diagnosis, an individual must exhibit two or more of the following indicators: 1) a marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics) 2) a strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics) 3) a strong desire for the primary and/or secondary sex characteristics of the other gender , 4.) a strong desire to be of the other gender (or some alternative gender different from one's assigned gender, 5) a strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender, and 6) a strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

The new criteria for Gender Incongruence suggest that there is not only a shift toward less pathologizing language ("incongruence" instead of "identity disorder"), but that there is an attempt to acknowledge that non-binary identities are valid expressions of gender variance. Also, the removal of the sexual orientation specifier (attracted to males, females, both, or neither) is appropriate, as sexual orientation should be of little or no consequence for making treatment decisions for those seeking medical interventions (DeCuypere, Knudson, & Bockting, 2010). These factors signify that the inclusion of Gender Incongruence is a shift in a positive direction in the de-pathologization of gender variance.

However, the diagnostic classification of "Gender Incongruence" is not without limitations as well. First, the new diagnosis may actually more broadly apply to gender variant individuals whose gender identity does not match their assigned sex, regardless of the level of distress (or lack thereof)

associated with it. Because the new diagnosis does not mention stress or impairment associated with gender incongruence, it is unclear why a diagnosis would be needed at all if it is not associated with clinically significant distress or impairment in functioning. One proposed response is that that impairment (due to stigma and discrimination) should not be necessary to qualify for the diagnosis, but *distres*s regarding the conflict between the body and the gender identity should be (DeCuypere, Knudson, & Bockting, 2010).

While the final outcome remains to be seen, there is concern that the new diagnosis of gender incongruence will lend continued justification to gender-based stigmatization and discrimination. Proponents for the removal of gender variance as a mental health disorder propose that all diagnoses regarding gender non-conformity be eliminated from the DSM-V completely and that the mental health needs of gender non-conforming people be addressed using existing diagnoses (i.e., depression, anxiety). A further suggestion is for a diagnosis to be created for those who require medically necessary gender-specific health interventions, and that the APA be asked to advocate for a transgender medical diagnosis in the ICD. Although the debate regarding the appropriateness of the DSM diagnosis will likely continue, the current diagnosis of gender identity disorder currently plays a key role in the recommendation for hormonal and surgical intervention (Hale, 2007).

Standards of Care for Medical Treatment of Gender Identity Disorder

The World Professional Association of Transgender Health (WPATH) is an international organization that is devoted to the understanding and treatment of transgender individuals. The mission of WPATH is to promote evidence based care, education, research advocacy, public policy, and respect in transgender health (World Professional Association for Transgender Health, 2012). WPATH is also responsible for setting forth the current standards of care for Gender Identity Disorders. The standards of care are the international guidelines which articulate professional consensus about psychiatric, psychological, medical, and surgical management of gender identity disorder, with the goal of "lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment" (Meyer, et al., 2001, p. 1). The standards serve as a set of treatment guidelines for therapists who are responsible for guiding the medical transition process for individuals who desire hormonal or surgical intervention.

According to the current standards of care, it is the responsibility of the mental health professional to be the "first contact" with the transgender person seeking medical intervention to ascertain an individual's eligibility and readiness for gender-related medical intervention. A qualified mental health professional may come from one of a number of disciplines, including psychology, psychiatry, social work, or nursing. The master's level clinician, per the standards of care, should have specialized training in the assessment of DSM disorders, competence in psychotherapy, and continuing education in the treatment of GID. The mental health professional is responsible for providing the client's physician or surgeon with clinical documentation (often referred to as "the letter"), supporting the person's history, eligibility, and readiness for hormones or surgery. Another role of mental health professional is to ensure that gender dysphoria is not secondary to or better accounted for by other diagnoses.

The current eligibility requirements for adults seeking hormone therapy are that the client must be at least age 18, must be able to make informed consent about the risks and benefits of hormone therapy, and must be initiated with a referral from a mental health professional. For surgery, one

referral must be initiated by a mental health professional for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty). Two referrals are needed from mental health professionals who have independently assessed the patient for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent.

It has been suggested that the standards of care are "classist" (Hale, 2007), and this raises an interesting concern for members of the transgender community who have limited financial resources, and who use publicly funded mental health insurance (Medicaid) to receive mental health and medical interventions. Because mental health practitioners share legal and ethical responsibility for referring/authorizing a patient for services, they are reluctant to do so after just one meeting, requiring lengthy engagement in therapy. Psychotherapy itself is a significant financial burden, and for transpeople who rely on the public mental health insurance plan may be denied care because "gender identity disorder" is not a covered diagnosis under the county's mental health plan. Further, many county mental health plans offer brief and emergency crisis intervention only, which would not meet the requirements for psychotherapy as outlined in the standards of care. Finally, clients who receive services within the public mental health system are often restricted in their choice of where they can receive care, and if a transperson lives in a county where a gender specialist is not employed, they may not be eligible to begin the transition process or may not receive proper care. It is unclear what the standards of care suggest in this situation, as they make no mention of how those with limited economic resources should go about negotiating through a very complicated (and often, a very costly) mental health system.

A related concern, specifically for economically disadvantaged transpeople, is that a transgender individual who is seeking gender transition services must rely on their mental health clinician as "gatekeeper" to accessing medical services. For this reason, it has also been suggested that the standards of care violate the medical principle of respect for autonomy (Hale, 2007). Specifically, the concern is that non-transgender patients who request medical intervention for gender related surgeries (such as breast enhancement in biological women and vasectomy in biological men) do not require psychological counseling first, and the professional gate-keeping role produces the assumption that transpeople who desire medical intervention are unable to make their own choices. Hale (2007) also suggests that the standards of care are pathologizing because they begin with the diagnosis of a mental health disorder, and that they deny gender variant people "full-moral status" (p. 16). Hale suggests that decisions about hormones and therapy should be made by physicians, not mental health professionals, after an informed consent process.

Although the standards of care present numerous challenges, particularly for those with limited economic resources, the gate-keeping role can be an asset as well as barrier (Bockting, 2008). For example, the mental health professional can be instrumental in helping a transperson come out to family and friends, confronting internalized transphobia, finding a comfortable expression of gender, discussing gender identity vs. sexual orientation, and exploring the goals and outcomes of medical interventions. Mental health professionals may be in a unique position to provide support and education, to ensure informed consent, and to help maximize self-determination. Overall, the gate-keeping role has been criticized because it has served as a barrier to accessing necessary services for gender variant individuals, but with the proper training regarding gender variance, mental health

clinicians may serve as a much-needed support system for transgender individuals who are undergoing a significant life transition.

Informed Consent Model of Care

A newly emerging approach to transgender health care is the "informed consent model" of transgender care (Informed Consent for Access to Trans Health, n.d.). This approach to transgender health care a) promotes a departure from the use of the diagnosis of "gender identity disorder" as a prerequisite for accessing transition services, and b) attempts to impact the way that transgender individuals experience and access healthcare by removing the psychotherapy/gatekeeping requirement. Instead of a mental health practitioner assessing eligibility for and granting access to services, transgender patients themselves are able to decide upon whether they are ready to access transition related health services. In this model, the role of the health practitioner is to provide transgender patients with information about risks, side effects, benefits, and possible consequences of undergoing gender confirming care, and to obtain informed consent from the patient. Because this approach to transgender care is so new, there is essentially no research highlighting transgender patients' experiences in receiving care under this model. It is the aim of this current study to continue to shed light on this topic, and to explore the ways in which transgender patients can receive non-pathologizing health care services.

Statement of Purpose and Research Questions

While there is a history within mainstream models of gender variance of pathologizing individuals and/or assuming that transgender identity is a "disorder" in need of treatment, a more trans-affirming perspective is to assume that " gender variance is as natural as any other expression of gender" (Lev, 2004, p. 5). This current study focuses on the challenges that transgender individuals face in light of being part of a socially marginalized group, not as an innate disorder, pathology, illness, or disease. This research explores the medical and mental health care experiences of individuals who identify their gender somewhere along the transmasculine spectrum. Specifically, the study addressed four main research questions: 1) What is the process of transmasculine identity development, and how do transmasculine individuals express and understand their identities? 2) What are the experiences of transmasculine individuals in seeking and receiving medical, mental health, and social services? 3) How do transmasculine individuals express their identities, both verbally and non-verbally, to health and mental health providers? And, 4) What role (if any) do interactions with medical, mental health, and social services providers and systems play in transmasculine identity development?

Using a qualitative grounded theory approach, data were collected through semi-structured interviews with 28 transmasculine identified individuals. Additionally, results from a pilot study with 15 gender-queer identified individuals supplemented the interview data. Participants shared their experiences in seeking and receiving health and mental health services across a variety of settings, including private therapy, university hospitals, public clinics, and primary care physician offices. The interviews focused on transmasculine identity development and experiences in seeking and receiving health care services. Participants also discussed how interactions with individual health and mental health care providers, insurance providers, and the larger health care system impacted (both positively and negatively) their experiences of gender identity development.

This study has several unique qualities, including its focus on masculine-identified individuals with diverse gender identities (instead of only including those who identify as "male" or those who

have medically transitioned), and its focus on recipients of service across a variety of healthcare settings. It not only provides valuable insight into the nature of barriers to access that transmasculine individuals face in health settings, but through examining the identities and lived experiences from a non-medicalized, social-psychological framework, the complex interactions between transmasculine individuals and medical professionals (doctors, nurses, and social workers), health care organizations, and insurance companies are highlighted. Further, while variant gender identity is often viewed as an individual "problem" or disorder, the results of this research highlight that there are complicated individual, social, and political components to the development and maintenance of transmasculine identities.

Chapter 2: Literature Review

The purpose of this chapter is to provide a review of the current literature pertaining to the transgender community. It begins with a brief discussion of key concepts from theories of gender development from multiple disciplinary perspectives. Next, it provides an overview of models specifically related to transgender identity development. Also, it provides an overview of the health and mental health care needs for members of the transgender community, including the barriers that transgender individuals face in accessing medical and mental health services. Finally, gaps in the literature are identified and a conceptual framework for this current study is discussed.

Overview of Models of Gender Identity Development

Core concepts in theories of gender identity development have emerged from multiple disciplinary perspectives. Psychological models of gender identity development focus on the early years of a child's development and emphasize the role of cognitive processes and family relationships on the development of gender identity. One prominent psychological model is based on psychodynamic theory (Freud, 1962). According to this theory, both boys and girls identify initially with their mother, and between the ages of 3 and 5 they begin to identify with the same-gender parent. This occurs in response to the need to resolve erotic attachment toward the opposite sex parent. According to Freud, a key component of gender identity development is the discovery that boys and girls have different genitals. Upon making this discovery, boys assume that girls have been castrated and fear that the same will happen to them, so they begin to identify with their fathers and desire their mothers sexually. Conversely, girls develop penis envy and identify with their mothers in order to win their fathers' love. This theory portrays sexuality as fixed, stable and dependent upon the embodied/physical aspects of gender differences. Contemporary psychoanalysts (Chodorow, 1991) have criticized Freud's work for being too androcentric, and have offered alternative explanations for gendered behaviors such as "womb envy" (Horney, 1967).

Social Learning Theory (SLT) and Cognitive Developmental Theory (CDT) were also influential in developing an understanding of childhood gender identity. Social Learning Theory concentrates on social sources of information about gender and shares basic principles from the school of behaviorism (Bandura, 1977). In SLT, the concept of reinforcement is prominent, which is the idea that children acquire gender identity by being rewarded for gender appropriate behaviors and punished for inappropriate behaviors (Bandura, 1977). Children also learn through modeling gendered behaviors. In this model, behaviors precede cognitions, and the emphasis is on the influence of environmental vs. internal factors (Mischel, 1966). Conversely, from the perspective of Cognitive Developmental Theory (CDT), children use gender as a way to organize their social worlds (Piaget, 1932). These theories focus on the nature of the gender structures involved in information processing. These organizing categories are called schemas and are used by children to develop their own gender identities (Piaget, 1928). From this perspective, gender is a basic organizer of learning and is fixed and irreversible. Major concepts in CDT include gender identity (ability to label oneself male or female), gender stability (the notion that gender remains constant), and gender constancy (recognition that superficial changes in appearance will not change one's gender). In these models, cognitions precede behaviors, and identity as male or female is both what drives gendered behaviors and serves as an organizer and motivator for interactions in the social world.

Using concepts from both SLT and CDT, Bussey and Bandura (1999) developed a Social

Cognitive Theory (SCT) of gender role development. By integrating both psychological and socio-structural approaches to gender, SCT offers an integrated perspective about how social structures influence behaviors. In SCT, internal variables (emotional states) play an important role in the emergence of gendered behaviors. Also, children are influenced by and create their own environments based on these internal variables by choosing highly gendered peers and/or gendered toys. In similar approach to gender identity development, Bem (1981) attempted to incorporate the role of society in individual differences in the processing of gendered information. In Gender Schema Theory (GST), children form schemas (organized networks of information) that influence their behaviors. In this model, schemas are formed primarily though interactions with the environment, and a child plays an active role and is motivated to adhere to gender norms. With further development of the theory into Enculturated Lens Theory, there were hidden cultural assumptions about how men and women look, behave, and act, which are rooted in social interactions and cultural discourse (Bem, 1993). From this perspective, gender development is social rather than biological, and is organized around three key concepts: 1) gender polarization (males and females are fundamentally different and organize society and life around differences), 2) androcentrism (males are superior to females and are the standard by which women are judged) and 3) biological essentialism (this rationalizes and legitimizes the differences by viewing them as inherent biological differences). Gender acquisition in this model is both a process and a product of enculturation.

In addition to theories which focus solely on cognition (psychological/psychodynamic) or those which attempt to integrate social/behaviorism with cognition (as in SLT, CBT, and ELT), sociological theories about gender development focus on gender as a social construction. In these models, social structures (socioeconomic status, education, occupation) and gender stereotypes shape the perceptions and treatment of males and females. The differences in genders are due to socialization, transferring norms, values, and behaviors that people are socialized to classify as male or female. From structural functionalist sociological perspectives, the genders complement each other, because women take care of the house and children and men provide for the family (Kessler & McKenna, 1978).

The mainstream disciplinary approaches to gender identity development have been critiqued by feminist, postmodern, and queer theory scholars who have attempted to incorporate alternative perspectives, reject the male/female binary, and question the constructs of gender, sexuality, masculinity, and femininity. Some feminist postmodern scholars (Haraway, 1991) believe that gender is a human creation, not a natural one; others suggest that gender identity is neither psychological nor biological, but is created solely through institutionalized power dynamics and historical interpretations of gender dynamics (Butler 1993; Halberstam, 1998; Sedgwick, 1990). Others believe that challenging the gender binary will allow for more fluid expressions of gender identity and will allow for the recognition of gender categories outside of male and female (Wilchins, 1997, Bornstein, 1994).

Nurture vs. Nature debate for Medical Management of Gender Variance

Although there are clearly a number of potential factors contributing to gender identity development in children, the ideas about the development of gender identity as "male" or "female" have been strongly influenced by a debate centering around the medical management of individuals with disorders of sexual development. The mainstream understanding of gender variance is rooted in the psycho-medico discourse regarding the medical management of individuals born with non-standard bodies, or those who grow to have non-standard identities. Much of the work in this area is rooted in the work of Dr. John Money, a pediatric psycho-endocrinologist whose wrote extensively about sex and

gender development, basing his writings primarily on clinical case studies of individuals seeking care at the Johns Hopkins University's gender clinic (Money, 1987). According to Money, gender identity does not develop until approximately the age of two, and is fixed and stable very early in life (Diamond & Sigmundson, 1997b). Also, an individual's sex of rearing (whether they were raised as a girl or a boy) predicts adult gender role and sexual orientation more strongly than anatomical sex (Fausto-Sterling, 2000). In this view, the sex or gender identity of a person is dictated primarily by both the appearance of the external genitals and the gender category in which one is reared.

Money insisted that outward appearance of the genitals is more influential in gender identity development than karyotype or pre-natal hormones. Money suggested that for healthy gender identity to form, boys needed an "adequate" penis, and girls required the absence of a phallus (Harper, 2007). Money and colleagues developed this theory of psychosexual development based primarily on clinical case studies of approximately 200 hermaphrodites (defined as persons with some degree of sexual ambiguity, anatomically and physiologically) of different diagnostic characteristics. They compared the gender role that was eventually established in childhood with the sex that was medically assigned in infancy. Using data from observational notes and clinical interviews, they determined that "sex of assignment and rearing is consistently and conspicuously" a more reliable determinant than the chromosomal, gonadal, or hormonal sex (Money & Ehrhardt, 1971). The key was the person's gender role (defined by Money as "everything that a person says and does to indicate to others or to the self the degree that one is either male, or female, or ambivalent") being established and reinforced consistently, not only through the surgical construction of gender-appropriate genitalia, but through haircut, dress, and the choice of toys provided to the child.

Money's theory was, in his view, supported by the now well-known case study in which 8-month old Bruce Reimer's penis was burned off during a routine circumcision in 1966. After seeing Dr. John Money on a TV talk show, Bruce's parents sought help at the Johns Hopkins Gender Identity Clinic, where John Money recommended that the baby be raised as a girl. The parents consented, and the baby had surgery to remove his testes and create female genitalia and was renamed Brenda. John Money encouraged the family to never tell the baby the whole truth about his history, stating "she shouldn't know she wasn't a girl" (Colapinto, 2000).

The baby had a twin brother, who served as Money's "control". Money wrote extensively about this case over the years, referring to the case as "John/Joan", and claiming that the gender transformation was successful. Money used this case to support his hypothesis that in male patients without a functioning penis, reassignment as a girl through genital surgery and parental reinforcement are the recommended courses of treatment, particularly if the surgery is performed early enough (Money & Ehrhardt, 1972). What Dr. Money did not reflect in his case reports is that Brenda consistently struggled with her assigned gender role until the age of 14, when she was finally informed by her parents about her circumstances and made the decision to transition back to male. Brenda renamed himself David and underwent hormone therapy and multiple surgeries to "undo" the effects of the female hormones he had been given to induce female puberty. David made his story public in 1997 when he was interviewed for Rolling Stone, and his story was subsequently developed into a book focusing on the family's interactions with Dr. Money and David's lifelong struggles with being assigned the "wrong gender" (Colapinto, 2000). Although Money continued to claim the case as a "success", and he later wrote that it was "lost to follow-up", David Reimer eventually committed suicide at the age of 38.

Milton Diamond's Biased Interaction Theory of Psychosexual Development

The dismal outcome of the "John/Joan" case has encouraged some medical professionals to more closely examine the evidence upon which John Money's theory was based. One of the earliest and most influential critics of John Money's work is Dr. Milton Diamond, Ph.D., professor of anatomy and biology. After reading Money's ongoing assertion that gender of rearing overrides biology in the shaping of gender, Diamond coordinated with David Reimer's treating psychiatrist, Keith Sigmundson, to provide evidence that John Money's "John/Joan" case study was not, in fact, successful, and that this case was "evidence that a gender identity and sexual orientation are largely inborn" (Colapinto, 2000).

Where Money believed that gender identity and behaviors were strongly influenced by rearing, Diamond saw gender identity as determined primarily by biology, specifically by prenatal hormones. His theory postulated that hormonal exposure while in-utero and just after birth encodes the brain as either male or female (Diamond, 1965, as cited in Karkazis, 2008). In this paradigm, now called the Biased-Interaction Theory of Psychosexual Development, Diamond (2006) asserted that early biological factors influence predisposition in social temperament and attitudes. These predispositions cause individuals to establish preferences and aversions that allow individuals to compare themselves to others; that is, individuals develop their gender identities based on whether they feel more like their male or female peers. Although one starts out with a "gendered brain", it is interactions with others that ultimately guide how an individual identifies her or his gender. Identity development is impacted by "Organizing Factors" (including pre-natal genetic and hormonal influences), which are "activated" by puberty or post-pubertal events or processes. Also, the family, culture, and environment influence sexual development, but do not ultimately determine it. Both Reiner and Diamond argued for a biological basis for gender identity, asserting that gender identity is based on hormones, is not malleable, and cannot be socially or medically determined.

Etiology of Gender Variance

Just as there are many approaches to understanding how non-transgender individuals come to identify as "male" or "female", there are various approaches to understanding how transgender individuals develop their gender identities. The etiology of gender variance is unknown, and this overview of theoretical perspectives serves to provide a basic understanding of the broad range of explanations for transgender identity originating from the fields of medicine, psychology, and sociology.

There have been a number of historical attempts to explain the roots of transgender identity as due to a medical disorder or mental illness. Magnus Hirschfield (1923) was the first to coin the term "transsexual" as a clinical category, and to recommend sexual reassignment surgery (SRS) as an intervention for transsexuality. Other early sexologists (Benjamin, 1966; Cauldwell, 1949; Krafft-Ebing, 1947) shaped the modern approach to both considering transgenderism a psychopathology as well as the recommendation for medical interventions (hormones and surgery) to treat the condition. More recently, within the biomedical community, there have been various attempts to explain the cause of transgenderism as a physiological condition located in the structure of the brain. Biological factors contributing to gender identity begin with the assumption that there are "normal" pathways to the development of the brain, and that male sexual development occurs in the presence of sufficient amounts of testosterone in the pre-natal fetus, whereas female sexual development occurs in the

absence of testosterone (GIRES, 2008). These theories also assume that biology dictates gender identity, and that transgender identity occurs when an individual's brain does not develop in line with his or her physical body. Reasons for this could include abnormal perinatal endocrine history, excess of androgens in females and lack of androgens in males, and the morphology of sex-differentiated brain nuclei (Cohen-Kettenis & Gooren, 1999). For example, Kruijver & colleagues (2000) explored the nuclei in the hypothalamic area of the brain and found that in transgender women, the size of this neuron was found to be in the same range as the female controls. It is important to note that the sample size (7 transgender women compared to 13 female controls) is most likely too small to draw any definite conclusions. Biological theories of transgender identity assume that gender identity is inherent, fixed, and rooted in a person. While "it is undeniable that biology sets a blueprint for sexual and gender expression" (Lev, 2004, p. 115), the results of these studies should be interpreted cautiously.

Parental and family psychopathology have also been cited as possible explanations for the cause of developing a transgender identity. These theories are based on assumptions of psychodynamic theories which assume that gender identity in gender-normative children emerges when children identify with their same-gender parent and healthy gender development results in a normative heterosexual identity (Lev, 2004). These theories of transgender identity development assume that something has "gone wrong" in the process of child-rearing which has impacted the healthy development of the child. Suggested family influences have included rearing factors such as extreme closeness to or overbearingness of the mother (Person & Ovesey, 1984), an unavailable mother (Green, 1987), or a mother who is intimidated by male aggression and encourages femininity in sons (Zucker & Bradley, 1995). While some theorists have blamed mothers for "creating feminine sons" (Stoller, 1968), others have blamed fathers for causing transgenderism in their children by being absent and not allowing their sons to "identify properly with masculinity" (Lev, 2004, p. 122). Psychological theories emphasize above all else the importance and role of the gender modeling by the same sex parent and attribute transgender identity to "developmental lag" (Zucker, 1999).

Many of these theories are directed toward transgender people generally (regardless of natal sex), but a few theorists have aimed to specifically explain transmasculine identity development from a psychological perspective. Stoller (1982) made an early attempt to explain transmasculine identity development as a result of female children not getting enough attention from their mothers, who then turned to their fathers who encouraged their development as male. Lothstein (1983), drawing on the work of Stoller, focused on the role of the health care system in granting access to transmasculine individuals who wished to transition medically, saying that FTMs should be "counseled out" of the identity instead of granted access to transition.

Clearly, there are a wide range of potential explanations for why some people are transgender, most of which share in common the assumption that there is something inherently "wrong" with non-normative expressions of gender. These theories are problematic because they tend to imply that there is a "cure" for transgenderism, with the goal of "fixing" the transgender condition. Whether transgender identity is rooted biologically or socially constructed has yet to be determined, but regardless of etiology, it is important to emphasize that gender variance is a valid expression of self and a reflection of the variation that exists in the world, without assuming that being transgender is a condition to be "fixed" or "cured". There are various theoretical perspectives about whether gender variance is a result of genetic predisposition, psychological orientation or social values about gender, and it is likely that the cause is a complex nexus of factors including genetics, socialization, environment, personality, and society. In addition to the cause for transgenderism, there is limited

research focusing on the process of transgender identity development. Although there have been a number of attempts over the years to describe the process of identity formation in sexual minority groups in general (Cass, 1979; D'Augelli, 1994; Troiden, 1979), these models focus on lesbian and gay "coming out" and typically do not apply to the transgender experience.

One notable exception is the "Witnessing and Mirroring" fourteen stage model of transsexual identity formation (Devor, 2004). Devor's model, which is presented in the context of social psychology, is unique in that it is based on a wide variety of NON-clinical settings. The author suggests that "in order for persons to legitimate their gender identity claims, they must ultimately have bodies which match their gender claims in socially expected ways" (Devor, 2004, p. 45). The author also suggests that a key aspect of transgender identity development is the need for transpeople to be seen by others as who they are (witnessing), and the need to be seen by others who have inside knowledge of what it means to be transgender (mirroring). The 14 stages include: 1) Abiding anxiety; 2) Identity confusion about originally assigned gender and sex; 3) Identity comparisons about originally assigned gender and sex; 4) Discovery of transexualism; 5) Identity confusion about transexualism; 6) Identity comparisons about transexualism; 7) Tolerance of transsexual identity; 8) Delay before acceptance of transsexual identity; 9) Acceptance of transexualism identity; 10) Delay before transition; 11) Transition; 12) Acceptance of post-transition gender and sex identities; 13) Integration; and 14) Pride (Devor, 2004).

Similar stage models of transmasculine identity development have been proposed by other theorists to explain the process of transgender identity development. Lewins' (1995) model focused on male-to-female transgender women, and the stages include 1) Abiding anxiety; 2) Discovery; 3) Purging and delay; 4) Acceptance (of trans identity); 5) Sex reassignment; and 6) Invisibility. A similar model proposed by Bolin (1988) focusing on MTF transgender individuals outlined the stages of trans identity development to include 1) Separation (renounce role or status as male); 2) Transition (not one gender category or another); 3) Incorporation (begins to take on new status); and 4) Completion. In a model focusing specifically on FTM gender development, Rubin (2003) viewed the desire for medical transition not as body hatred, but as an attempt to secure "intersubjective recognition". In this model, the 'transsexual trajectory' included a) Finding the transsexual category; 2) Identifying with other transmen and men; 3) Disidentification from being women; 4) FTMs become invisible once they transition to men; and 5) Individuals undergo multiple stages of transition over a period of several years. Hansbury (2005) proposed that transmasculine identities exist on a spectrum, with male-identified individuals on one end, genderqueer individuals on the other, and with those who identify as "transmen" in the middle of the spectrum.

These models are useful in that they highlight the process that a transperson may undergo from the periods of pre-transition to post-transition, which may provide clinicians and transpeople themselves with useful understanding of the process that one may move through in developing a transgender identity . However, like many "stage models" of identity development, one limitation is that they assume that individuals move through the stages in a linear fashion, and that if an individual does not move past a certain stage then he or she is developmentally "stuck" there. For example, in Devor's model, pride in transgender identity occurs post-gender transition and after a period of successful living and "passing" in the proposed gender category. In the lives of some gender variant individuals, a feeling of pride may occur before surgical intervention. Other transpeople may take hormones and transition to a gender neutral category where comfort in their chosen gender category is not dependent upon disidentifying with their original gender and sex category, as suggested in Devor's

model. Also, these models assume that gender identity development stops after medical interventions are complete, which may not always be the case. Finally, it is important to consider that transpeople with limited economic resources, particularly those who are homeless, unemployed, or otherwise socioeconomically disadvantaged may find other ways to express and experience their chosen gender that has little to do with medical transition status. More research is needed to explore the process of identity formation in transpeople who transition from their assigned gender category to a neutral or genderqueer category where social acknowledgement by non-transpeople as "male or "female" is not applicable.

<div align="center">Health, Mental Health, and Social Welfare Needs</div>

It is clear that transpeople are in a unique position with regards to receiving services to meet their health, mental health, and social welfare needs. Transpeople must rely on mental health professionals to determine their access to gender-related medical interventions, and are faced with many challenges as a result of the current standards of care. Regardless of the potentially conflicting suggested pathways to receiving health and mental health care, transpeople have significant gender-related and non-gender related health and social welfare needs that will be discussed below.

Several studies have documented the complex medical, mental health, and social welfare needs of those with transmasculine identities (or, transmen), which can be divided into two categories: routine care and gender related care. Routine health services consist of services related to prevention and primary care, such as annual check-ups, breast exams, and pap smears. Gender related care, or "transcare" (Rachlin, Green, & Lombardi, 2008), consists of medical services specifically related to the gender transition process, such as hormone administration, bilateral mastectomy and chest reconstruction ("top surgery"), and gender confirmation surgeries such as phalloplasty, metoidioplasty, and hysterectomy ("bottom surgery") (Israel & Tarver, 1997).

Transition Related Health Care Needs

Many transgender men enter the medical system for the purpose of acquiring hormone therapy (Clements-Nolle, Marx, Guzman, & Katz, 2001). Testosterone is either injected or provided in a transdermal patch, with the intended result of masculinizing the body. Prolonged testosterone usage can result in the development of male sex characteristics, including hair growth and increased muscle mass (Israel & Tarver, 1997). Transgender men can expect deepening of the voice, clitoral enlargement, increase in facial and body hair, increased sex drive, and male pattern baldness. The major risks associated with excessive testosterone dosages include increase in cholesterol, heart disease, and mood changes such as irritability and depression and increased risk of ovarian, cervical, and breast cancers.

Despite the potential side effects and health risks involved, testosterone use is a significant health need among transgender men. In an Internet-based survey with a sample of 321 transgender men, 71% reported using testosterone, while under half (43%) reported having completed chest surgery (Forshee, 2008). The results from the survey mirrored another Internet-based survey with 384 transmen, where 68.1% were using testosterone, 37% had top surgery, and only 3% of the sample had bottom surgery (Newfield, Hart, Dibble, & Kohler, 2006). Interestingly, the results of a short questionnaire regarding medical care in a sample of 122 transmen indicated that 76% of the respondents (n=93) were using testosterone and either already had or planned to have chest surgery; only one respondent already had bottom surgery, with 4% (n=6) planning to do so in the future

(Rachlin, et al., 2008). This speaks to the need for social, legal, and medical policies that reflect the fact that many transgender men forego "full" surgical intervention for a number of reasons. While some transmen may simply not desire "bottom" surgeries, others may be deterred by the high cost of surgery and unpredictable surgical outcomes for phalloplasty in this population.

There is evidence to suggest that the usage of testosterone significantly improves overall quality of life. Newfield and colleagues (2006) conducted an Internet based survey aimed at exploring the quality of life (QOL) of transgender men using the Short Form 36-Question Health Survey, and results from a sample of n=384 transmen were compared to results from the general population. The results indicated that while transmen experience an overall lower quality of life than males and females in the general population, transmen respondents who had used testosterone (n=301) reported an increased quality of life compared to those who had not used testosterone (n=83) in the mental health domain. Similarly, those who received "top surgery" reported heightened quality of life scores in the domains of general health, social functioning, and mental health when compared to those who had not had surgical intervention (Newfield, et. al, 2006). There is further evidence to suggest that bilateral mastectomy, or "top surgery", is an important part of the transgender experience as well: in a qualitative study (n=6) of transgender men, breasts were reported to cause the most gender identity conflict (Dutton, Koenig, Fennie, 2008).

HIV/AIDS

Another significant health-related concern for transgender men is sexual health and exposure to HIV/AIDS. Clements-Nolle and colleagues (2001) conducted in-depth interviews with 123 transmen regarding their health and sexual behaviors. Of these, 27% reported unprotected receptive anal sex with a male partner, 63% reported unprotected vaginal sex with a male, 59% reported forced sex or rape, and 31% had a history of sex work. In another study exploring the HIV risk among transgender people, 32 transmen respondents reported a significantly lower level of AIDS knowledge than the comparison group, and over half (56%) had not been tested for HIV/AIDS despite participation in high risk sexual behaviors (Kenagy, 2002). Further, Kenagy & Hsieh (2005) analyzed the data from two needs assessments which were conducted through face-to-face interviews with transgender men and found that compared to transgender women, transmen respondents were less likely to use protection during sex and significantly more likely to have engaged in high-risk sexual activity. In another study exploring the HIV risk factors for transgender men who have sex with non-trans men, (n=45) transgender male respondents reported inconsistent condom use: 60% of the sample reported that they did not always use condoms during anal sex and 70% reported they did not always use condoms during vaginal sex with men (Sevelius, 2009). Other risk factors include use of drugs and alcohol during sex and reduced ability to negotiate safe sex with men (Sevelius, 2009).

Transgender men are also at heightened risk for HIV due to agency-related barriers and lack of specific HIV services geared toward their unique needs. Some transmen desire to seek services through agencies serving non-trans men who have sex with men, although these agencies often mis-categorize them as non-trans or never give them an opportunity to identify themselves as transgender (Sevelius, 2009). The author emphasizes that more research is needed for HIV health risks in the transgender community, particularly for transgender men who engage in high-risk sexual activity with non-trans men. Collectively, these results indicate the need for sexual health education and HIV services that are both accessible and sensitive to the needs of the transgender community.

Mental Health

In addition to the need for medical services and transition-related health monitoring, transmen have significant mental health concerns. Findings from two Philadelphia-based needs assessments with a combined total of 70 transgender men indicate that of the 17 transmen in the sample who had attempted suicide, over half reported that that being transgender was the reason for their attempt (Kenagy, 2005). Results from in-depth interviews with 123 transmen regarding their health and mental health status revealed that 32% had attempted suicide, and 20% had been hospitalized psychiatrically; further, 55% the respondents met criteria for a diagnosis of depression according to the Center for Epidemiologic Studies Depression Scale (Clements-Nolle et al., 2001). In a sample of 24 male-identified transgender youth, nearly half reported serious thoughts about taking their own lives, citing factors related to making a suicide attempt including a history of physical and verbal abuse, low self-esteem, and thoughts of how others evaluated their bodies (Grossman & D'Augelli 2007). Clearly, depression is a significant health related concern for this population, and mental health services geared toward prevention, outreach, and culturally sensitive treatment for transgender men is of utmost importance.

Other Social Welfare Needs

The social welfare needs of transgender men are not limited to the medical and mental health sectors. Forshee (2008) conducted an Internet survey regarding general social services usage of transgender individuals, to which 321 transmen responded. The results indicated that 8% of the sample had used emergency housing, 11% had a history of drug and alcohol treatment, and 28% had required either food stamps or public sector medical services. While these numbers may seem low, it is important to note that this survey had a highly selective sample: n=296 reported at least some college or higher education, and 62% reported full-time employment. Therefore, the results must be interpreted cautiously and care must be taken to acknowledge the limited generalizability to transmen who lack access to employment and educational resources. Further research is necessary to examine the social welfare needs for transgender men who have limited education and employment opportunities and who receive most or all of their care through public sector social welfare settings.

In an analysis of needs assessment surveys conducted with 65 transgender men, Kenagy & Hsieh (2005) also found that 47% of the sample reported the need for job training, 29% reported a need for housing, 29% reported the need for mental health counseling, and 28% reported the need for welfare benefits. Transmen also reported the need for social services related to parenting skills, family planning, and childcare, significantly more than transgender women. It is interesting to note that none of the respondents in the sample had transitioned legally or medically. While it was unclear whether this was due to lack of desire for medical intervention or limited access to required services, the results indicate a heightened need for social welfare services geared toward non-medically transitioning transmen.

Barriers to Accessing Services within the Public Welfare System

Although their social welfare needs have been well-documented, there are several barriers to accessing services for transgender individuals, particularly those with limited social and economic resources. The barriers experienced by transpeople can be loosely organized into two categories: provider-related barriers and system-related barriers.

Provider-Related Barriers

Transgender individuals experience discrimination in social services, employment, health, mental health care, housing, legal and educational settings (Sausa, 2003). Barriers related specifically to provider discrimination are well-documented in the literature.   As a result of provider discrimination, transgender individuals tend to distrust providers and underuse health and social services as a result (Nemoto, et al., 2004). Transgender individuals may completely avoid seeking care due to negative past experiences of discrimination, provider hostility due to lack of sensitivity of transgender needs, and fear of disclosure of transgender status, particularly in social welfare agencies (Finnegan & McNally, 2002). If a transperson seeking services in a mental health clinic for depression or anxiety is assigned to a therapist who is not educated in the area of gender variance, "gender identity" may be inappropriately identified as the focus of clinical attention. This approach has been notably ineffective in the individual treatment of transgender individuals; in fact, mental health provider experience is a key factor in positive therapeutic changes and client satisfaction in both gender and non-gender related therapeutic relationships (Mallon, 1999; Rachlin, 2002).

Of the 53 respondents in the FTM Alliance (2004) survey, 53% reported that they had been denied services on the basis of their transgender status, and 68% reported that they avoid the medical community due to a history of negative experiences. In another survey of 384 transgender individuals, 312 (70%) delayed seeking care due to perceived provider discrimination (Newfield, Hart, Dibble, & Kohler, 2006). In their needs assessment of 248 transpeople, provider insensitivity and fear of disclosure to healthcare providers of transgender status was cited by 33% of the sample (Xavier, Bobbin, Singer, & Budd, 2005). As a result of fear of stigma, discrimination, and past negative experiences with providers, transgender people tend to over-rely on emergency medical and mental health care (Bockting, et al, 1998; Xavier, et al., 2005), which is not only costly, but it does not provide the continuum of care that is appropriate and necessary to address many of the health and mental healthcare needs experienced by members of the transgender community.

Mental health and healthcare providers may also make a number of assumptions regarding their transgender clients, and in the absence of transgender-sensitive agency policies, these assumptions may have a negative impact on service provision. Provider assumptions about the binary nature of gender can also pose a challenge for transpeople with non-binary identities simply because they transcend the normative gender categories of "male" and "female". Generally, there is a lack of acknowledgement among social services providers about the complexity of transgender identities and experiences. For example, mental health professionals may assume that transgender male clients are only eligible for gender confirmation surgery recommendations if they have a heterosexual orientation, while some transmen have reported attraction to non-transmen and/or other transgender men and actually identify as gay or bisexual (Bockting, Brenner, & Coleman, in press, as cited in Bockting, 2009). In this situation, the client may be denied access to medical intervention because it has been deemed that they "do not meet criteria" (Coleman & Bockting, 1988). As a result of provider assumptions about identity, transpeople may completely avoid disclosing their transgender status due to fear of negative or discriminatory treatment (GLBT Health Access, 2000). In the absence of agency intake forms questioning clients about gender identity and assigned sex, transgender people who "pass" in their preferred gender category are often not given an opportunity to identify themselves as transgender and do not feel comfortable disclosing it to providers who make assumptions about their gender.

System-Related Barriers

The health, mental health, and social welfare system are inherently structured in ways which pose a challenge to transpeople who receive services within these settings. The financing system in the United States for health and mental health care is also a significant barrier for transpeople seeking services. For example, although there have been attempts to gain insurance coverage for gender transition related medical services in the public sector, the current basis for federal reimbursement for gender-confirmation surgery is that the intervention is experimental and therefore is excluded from federally funded insurance plans (Israel & Tarver, 1997). Even when not related to gender transition services, access to health insurance is a concern for members of the trans community. In one sample of 128 transgender women, 40% reported having no health insurance (Harawa & Bingham, 2009); similarly, Xavier & colleagues (2005) reported that 60% of their sample had no health insurance, and 48% had the inability to pay out of pocket for healthcare services.

Many insurance companies exclude coverage for transgender related surgeries that they deem to be "cosmetic" or "experimental", even though non-trans people are often able to secure coverage for the same treatments. Even if the services are in no way related to gender transition, health insurance policies often deny routine care if the individual's documented gender category does not match the health needs dictated by their biological health risks. For example, while routine medical care should in most cases be completed on the basis of natal sex (i.e., transgender women should have routine prostate exams; transgender men who have not undergone hysterectomy should still receive routine pap smears), trans people are often denied insurance coverage because, as one primary care practitioner explained, "They won't pay for a prostate exam in a woman!" (Dr. Nina Birnbaum, Personal communication, May 2010). Health insurance policies denying care to transgender people on the basis of their gender status are discriminatory in nature and create a barrier to accessing services.

Even when insurance is present, transpeople may be reluctant to use it. In a survey of 53 members of the FTM Alliance in Los Angeles, 66% reported that they do not use their employer-issued health insurance due to fear of lack of confidentiality or lack of coverage for transgender services, and 63% reported that they cannot afford necessary medical services on their own (FTM Alliance, 2004). In another survey exploring the healthcare experiences of transgender individuals, the results indicate that although 82% had insurance and a primary care physician, nearly half did not obtain an annual health exam (Clements-Nolle, et al., 2001). Accessing health and transition related services may be even more challenging to transgender people of color, who reported having an established healthcare provider less often than their white counterparts (Kenagy, 2005). These results suggest that even when they have access to medical insurance, transpeople would benefit from increased access to a full spectrum of medical and mental health services.

Due to the structure of the public mental health and healthcare systems, clients receiving services in the social welfare system often do not have a choice of where to go for services, and as a result may not have access to agencies that provide transgender-sensitive healthcare. For example, clients in the public sector are typically required to receive services in the mental health and healthcare clinics located in their county of residence, and a master's level clinician with knowledge of gender issues may not be employed in that county. Thus, they may experience difficulty beginning the therapeutic process set forth by the WPATH standards of care. These barriers to accessing gender-related services for transgender individuals may lead to "black market" hormone use, which, if medically unsupervised, has been known to relate to illness and heightened risk of HIV infection (Lombardi, 2001). Many

transgender people may be receiving services involuntarily, and in settings such as acute care mental health, child welfare, and the criminal justice system, transgender individuals may be faced with discriminatory agency practices or lack of policies for working with transgender clients.

While an increasing number of state and local institutions are beginning to recognize the need for protection from discrimination for members of the transgender community, there is currently no federal law protecting individuals from discrimination on the basis of gender identity or expression. As a result, transpeople are routinely fired if transitioning while employed and face discrimination on the job market, resulting in a reliance on public assistance, where they are discriminated against in welfare offices, job sites, and welfare to work programs (Spade, 2006). Although efforts have been made to document the barriers to accessing social services for individuals in the transgender community, few studies have focused specifically on experiences in public sector.

Conceptual Framework

While the health needs and barriers to accessing services have been well-documented in the literature, there is a dearth of information regarding the experiences of receiving care, and how these experiences may impact one's identity development in a positive (affirming) or negative (pathologizing) manner. This current study will attempt to fill some gaps in the literature by exploring how interactions with health systems and individual providers impact transmasculine identity development. With the increase in interest regarding transgender identities, there has been a shift toward viewing those who upset normative conceptions of 'male' and 'female' not as mentally ill or disordered, but as an inspiration for transgressive body politics (Davis, 1997). Despite this perspective, the social work and health professions have often adopted an oppression model when working with clients who transgress gender norms, and the existing research from within the health care field often fails to reflect identities that exist outside of the binary gender system (McPhail, 2001). As a result, there has been a call from trans activists and healthcare advocates toward conducting research from a salutogenic perspective that focuses on the positive dimensions and successes of transgender lived experiences (Bornstein, 1994; Wilchins, 1997). One such example of this is the trans-health model (Singer 2006), which suggests that there are multiple gender identities and that non-standard bodies and identities should not be pathologized. This study will employ a trans-health framework to acknowledge that non-normative gender identity is not in and of itself pathological, but may contribute to discrimination and various barriers to accessing services within the social welfare system.

Transgender individuals who come into contact with healthcare and other social welfare providers may use the process as a mechanism by which to create and maintain identity; in this way, the social service providers themselves may have an important impact on the creation or development of self. While this may lead to relatively stable identities for people who have an identity in line with the categories of 'male' or 'female', this study will also consider how people without culturally intelligible gender identities negotiate through the process. This study will explore how providers and systems that cannot recognize non-binary identities may be tools of normalization for those who exist outside of this binary, and how this may itself be a barrier to accessing services for those who resist mainstream gender categorization. Within this study, the complex interactions between transmasculine individuals and medical professionals (doctors, nurses, and social workers), the larger social welfare system, the transgender community, and social networks will be explored.

Chapter 3: Methodology

Overview

The purpose of this study was to explore the medical and mental health care experiences of individuals who identify their gender somewhere along the transmasculine spectrum (that is, those who were 'assigned' or 'announced' as female at birth but who currently identify with a category other than female), across a variety of practice settings. The study addressed four main research questions: 1) What is the process of transmasculine identity development, and how do transmasculine individuals express and understand their identities? 2) What are the experiences of transmasculine individuals in seeking and receiving medical, mental health, and social services? 3) How to transmasculine individuals express their identities, both verbally and non-verbally, to health and mental health providers? and 4) What role (if any) do interactions with medical, mental health, and social services providers and systems play in transmasculine identity development?   Using a grounded theory approach, the research questions were investigated through the use of in-depth, semi-structured interviews with 28 transmasculine individuals. This chapter begins with an overview of the rationale for qualitative research, which is followed by a discussion of the key elements of grounded theory and its theoretical underpinnings. A description of the research sample, the procedure of data collection, the analysis and synthesis techniques, and ethical considerations follows.

Rationale for Qualitative Approach

Because this was an exploratory study concerned with the nature of the experiences of transmasculine/genderqueer individuals, a qualitative approach was the most appropriate for answering the research the questions.   A qualitative approach "embraces the idea of multiple realities" and focuses on subjective meanings and experiences of participants (Creswell, 2007). Qualitative researchers also seek to understand how social meanings are constructed, and to understand how experiences can co-create reality through interactions, language, and dialogue. In this approach, individuals seek understanding of the world in which they live and work, and the research relies "as much as possible on the participants' views of the situation" (Creswell, 2007, p. 20).

A qualitative approach was appropriate for this study because a key element in this research was to capture the participants' perspectives and experiences in receiving medical and mental health services, with an interest in how interactions with healthcare providers impacted identity development. This approach allowed the participants to explain their process of gender identity development freely, as opposed to confining them to mainstream identity paradigms such as "male", "female", or "transgender". A qualitative approach also allowed the researcher to situate concepts of transmasculinity both socially and historically, and allowed for a more in-depth and complex understanding of both the process of defining oneself as transmasculine and the nature of the individuals experiences in receiving health and mental health care. Finally, this approach allowed a more in depth examination of the processes involved with interacting with health and mental health care providers, and allowed for a complexity of views rather than using narrow meanings or categories to define participant experiences.

Grounded Theory Overview

The methodology used to guide the design and analysis in this study was grounded theory (Charmaz, 2006; Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1998). The term "grounded theory" has been used both as a methodology (i.e., "Doing" grounded theory) and as an outcome (i.e., the product of a grounded theory analysis) (Bryant & Charmaz, 2007). Grounded theory as a research methodology was developed by sociologists Barney Glaser and Anselm Strauss (1967), and it claimed to offer social researchers a method for creating or generating social theory grounded in empirical data. Glaser and Strauss first developed the method in their study "Awareness of Dying" (Glaser & Strauss, 1965) that examined the care of dying hospital patients. It is an inductive method aimed at middle-range theory development or "abstract renderings of specific social phenomena grounded in data" (Merton, 1957, as cited in Charmaz, 2006, p. 9), as opposed to deductively deriving concepts from an existing "grand" theory.

Theoretical Underpinnings of Grounded Theory

The grounded theory method has its roots in symbolic interactionism (Heath & Cowley, 2004), most notably in the theoretical work of Herbert Blumer (1969). Symbolic interactionism is a social-psychological theoretical perspective that was built upon the work of George Herbert Mead, whose work laid the foundation for the symbolic interactionism approach (Blumer, 1969). Symbolic interactionism is based on three premises: 1) Human beings act toward 'things' (including other people, objects, institutions, etc.) on the basis of the meaning that they ascribe to those things; 2) The meaning of such things is derived from social interaction that one has with others and with society; and 3) These meanings are handled in and modified through an interpretive process used by the person dealing with the things s/he encounters. Key to this theoretical approach was also Charles Cooley's (1902) concept of "the looking glass self", which put forth the notion that individuals are self-aware, are able to see themselves from the perspectives of others, and shape themselves based on the perceptions of others.

In his work focusing on the theory of symbolic interactionism, Blumer (1969) critiqued the sociological methods that were used at the time and the use of variable analysis in the social sciences, stating, "social theory is not in touch with the empirical world". Blumer's work also confronted the problem that *concepts* in sociology and social theory were often vague and taken for granted by researchers, and, as a result, poorly defined. As opposed to the operationalization of concepts, social theory emphasized the value of "*sensitizing concepts*" (such as norms, personality, social system, institutions, and structures). Sensitizing concepts can be grounded on sense and enriched by the data that inform them (Blumer, 1969). The methodology of grounded theory was developed as a method which valued developing an understanding of phenomena based on data, and less defined by the operationalization of concepts. Grounded theory and symbolic interactionism view researchers themselves as social beings whose experiences, ideas, and assumptions contribute to their understanding of social processes.

Grounded Theory Methods

In "The Discovery of Grounded Theory", Glaser & Strauss describe their approach to the analysis of empirical data (Glaser & Strauss, 1967). Grounded theory was developed to examine the data and generate new *categories* and their *properties*. It also constantly redesigned and reintegrated a core category, or theoretical notion (Glaser & Strauss, 1967). In this paradigm, a category is a

conceptual element of theory, while a property is a conceptual aspect or element of a category. The example given from their own work explained the difference between concepts and categories using their study on the interaction between nurses and their dying patients. In their study, one category of "social loss" was developed to explain how nurses think about their dying patients in terms of the loss that their death would mean to those around the patient. The "theoretical properties" of the category of social loss included the explanation that some people have high social loss and some have low and that patient care varies based on the degree of social loss (Glaser & Strauss, 1966). The properties are used to describe the different elements of the larger category, and a category or categories are used to develop a larger grounded theory.

Both categories and properties are *concepts* indicated by the data (they are not the data itself). To this end, grounded theorists rely upon the use of the "constant comparison" method of coding of all relevant data, systematically assembling it, and analyzing it in a way that would constitute "proof" (Glaser & Strauss, 1967). The constant comparison method of analysis included four stages: 1) comparing incidents in the data which were applicable to each category (while coding an incident in a category, comparing it with previous incidents in the same and different groups; 2) the integrating of categories and their properties when the constant comparison of incident with incident in step 1 evolves to comparing incidents to properties of categories; 3) delimiting the theory (or, discovery of underlying uniformities in the original set of categories) and 4) writing the theory, using coded data and analytical memos to develop the theory (Glaser & Strauss, 1967). In this method, the researcher moves from the data to more abstract categories until all of the variation in the data is accounted for, resulting in theoretical saturation; that is, no new categories emerge from the data, and the relationships between different categories are made clear and are adequate in explaining the process under study. The goal is not to simply list themes, but to take the data to a conceptual level.

In addition to the use of the constant comparison method described above, there are a number of other characteristics defining the grounded theory methodology as developed by Glaser & Strauss. These included simultaneous data collection and analysis, constructing codes from data (not using preconceived codes), the use of theoretical sampling (sampling aimed toward theory construction, not population representativeness; please see sampling strategy for further discussion), and conducting the literature review after the data analysis (Charmaz, 2006). The reason for the suggestion to delay the literature review is that prior understanding of the topic should be based on the general problem area and more focused reading should occur when the emergent theory is developed (Glaser, 1978). However, in grounded theory analysis, both prior knowledge of the researcher and an understanding of the literature can be early influences in developing the study and defining the research questions to focus broadly on the phenomenon to be studied.

Constructivist Grounded Theory

Although Glaser and Strauss developed the grounded theory method jointly, they subsequently diverged on their ideas about what constitutes a grounded theory. In addition to the grounded theory approaches of Glaser & Strauss discussed above, Kathy Charmaz (a student of Glaser) developed an approach to grounded theory in which theories are not "discovered" from the data, but are "constructed", through the lens of the researcher, discipline traditions, and research practices (Charmaz, 2006). In constructivist grounded theory, unlike in classical grounded theory, the researcher is not viewed as separate from the data, and therefore, the researcher's biases must be made explicit. Constructivist grounded theorists view grounded theory as the product of a process that occurs through

interaction (Charmaz 2006). In constructivist grounded theory, "methods consist of systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories 'grounded' in the data themselves" (Charmaz, 2006, pg. 2). Charmaz draws on Blumer's notion of sensitizing concepts as general research interests, or points of departure, to form interview questions, examine data, and to think analytically about the data. This current study used constructivist grounded theory methods, including an emphasis on how the data and categories produced by the analysis must be understood through historical, social, and structural contexts.

In this current study, the main "sensitizing concepts" which guided the development of the research problem were my interest in transmasculine identity development, the concepts of medicalization (Conrad, 2007), and medical and mental health care access of members of marginalized communities. These concepts, combined with a strengths-based, non-pathologizing view of gender variance, have shaped the design and analysis of this study. The outcome is a model that explores how and when transmasculine people seek services (both related to gender transition and not), and how different components of transgender healthcare provision and interactions with providers can shape or impact transmasculine identity. Transmasculine individuals who come into contact with health care and other social welfare providers may use the interaction to create and maintain identity; in this way, the social service providers themselves may have an important impact on the creation or development of self. While this may lead to relatively stable identities for people who have an identity in line with the binary category of "male", this study also considers how people without culturally intelligible gender identities (i.e., genderqueer individuals) and individuals who have no desire to medically transition negotiate through the process. Also this study explores how providers and systems that cannot recognize non-binary identities may be tools of normalization for those who exist outside of this binary, and how this may itself be a barrier to accessing services for those who resist mainstream gender categorization. It is important to explore the ways in which social workers and other healthcare providers shape the lived experiences of those with gender identities that do not conform to the binary system of gender. Within this study, the complex interactions between transmasculine individuals and medical professionals (doctors, nurses, and social workers), the larger social welfare system, the transgender community, and social networks are explored.

Researcher Perspective

In keeping with the constructivist grounded theory tradition (Charmaz, 2006), my position as a researcher must be acknowledged, as I have several biases and assumptions that underlie this research. First, as a white, educated, cisgender[1] female, I acknowledge that I write from a privileged position; however, as a queer-identified individual and active ally to the transgender community, I bring unique personal experiences that allow for enhanced understanding of cultural neologisms and terminology that may be specific to the transmasculine community. Further, as a professionally trained social worker and mental health practitioner, I was particularly interested in how interactions with health care providers and health care systems (i.e., managed care and health insurance companies) impacted transmasculine identity development; thus, these disciplinary practices inevitably shaped the lens through which this research was conducted and analyzed. My personal beliefs about gender (that gender is not binary, that there should be more than two gender options in society, that all people deserve to express who they are without fear of discrimination, and that being transgender is not a

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1   Cisgender refers to a match between an individual's gender identity and their biological sex; it is a term that also means "non-transgender".

mental illness, but a human variation that should be celebrated and not pathologized) inevitably shaped both the methods and outcomes for this study.

Pilot Study

In preparation for conducting this dissertation research and to shape and sharpen the general areas of inquiry, I conducted a pilot study which served as a preliminary examination into how female-born individuals with non-binary (i.e., genderqueer) identities expressed and experienced their gender identities. The purpose of the pilot study was to investigate and examine the lived experiences of transmasculine gender-variant individuals who also identify as "genderqueer". Due to time and resource constraints, I was unable to complete in-person interviews with genderqueer individuals; however, qualitative research allows for diverse data sources and collection strategies, including the use of audio-visual material, journals, and observations (Creswell, 2007). The question ("how do individuals describe and express their genderqueer identities"?) was answered by viewing and transcribing online video journals recorded on personal webcams and uploaded onto youtube.com, a popular social networking site where individual users can upload videos to share with the public. This process, often referred to as "vlogging" (or "video blogging"), is a strategy for members of the transgender community to connect with other transgender community members and allies, and to share their gender transition experiences with others. When users upload a video, they add "tags", or descriptive words that allow other users to search for videos on a certain topic. Youtube.com was chosen for numerous reasons, including its availability and the public nature of the data.

Pilot Study Participants/Sampling

To locate participants for the pilot study, the main youtube.com homepage search engine was used to search for videos that included the term "genderqueer". While a majority of the videos in the search results were either educational in nature or videos of cultural performances, this study focused primarily on the personal video journal accounts of individuals who self-identified as "genderqueer" and who were also documenting their individual conceptions of being genderqueer. Once an individual was identified as "being genderqueer", their demographic data and screen name were recorded, and the applicable videos were viewed and transcribed, in order to capture an essence of how participants described their genderqueer gender identities. The sampling process produced 15 female-born individuals who identified their gender as genderqueer. A total of 61 videos from these individuals were included in the study, with 417 minutes of video footage collected. While youtube.com restricts videos from being more than 10 minutes in length, most users in the study (n= 13) had more than one video upload that related to their experience of being genderqueer. Total video footage per participant ranged from 5 minutes to 47.5 minutes, with the average being 27.8 minutes per participant. In an effort to keep the results somewhat recent, only videos uploaded by users between July 2008 and November 2009 were included in the analysis.

Pilot Study Sample Characteristics

Overall, the average age of study participants was 22 years old, with the range being from 15-26 at the time of video upload, with four participants not disclosing their exact ages in their videos. In terms of race, all but one participant was white, and one was African American. A majority of participants (n=12) had attended college in the past or were attending college at the time of video upload, one was unknown, and one was not yet college-aged. All participants acknowledged that they

were biologically female and all identified their gender identity as "genderqueer". Four participants were taking testosterone at the time of video upload, two were on testosterone in the past but had stopped taking it, two were actively planning to take testosterone in the future, and seven respondents were not on it and made no mention of starting it in the future. A majority of the respondents (n=11) had not had "top" surgery (double mastectomy/chest reconstruction to appear male), while the other four had completed it. In terms of sexual orientation, sexual identities included "lesbian", "pansexual", and more generally, "queer", although this information was not available for each participant.

Pilot Study Findings

The main themes that resulted are as follows:

1) Being Genderqueer: Describing genderqueer identities
      Of the sample, seven participants stated that they felt "both male and female", six described their genderqueer identity as "neither male nor female", and six stated that they felt "between male and female". Five participants felt "not completely male but not completely female", and five used other terms to describe their identities, such as "genderless" or "gender fluid". Many participants felt simultaneously "both" and "neither" which not only points to an inherent contradiction, but highlights the lack of available social categories for genderqueer individuals to express their genderqueer identities.

2) Genderqueer and "trans" identities
      In addition to using a description of binary gender characteristics to describe one's genderqueer identity, participants also expressed their genderqueer identities by describing how they *differ* from traditional female-to-male transgender individuals who were born female but who are transitioning to a social identity as male. Participants also spoke of how their genderqueer identities were often *in conflict* with an identity as transgender or male. These individuals conceptions are important because they highlight that genderqueer is not necessarily simply an "umbrella term" under which all gender-variant individuals fall. Instead, some individuals may experience "genderqueer" as separate and distinct from other transmasculine identities such as "FTM" (female-to-male transgender) or transgender.

3) Genderqueer as metaphor
      Often, the categories of "male" and "female" were not always adequate to describe an individual's conception of their genderqueer identity, and individuals used metaphors for their gender to convey that they identified outside of the binary. For example, participants described their genderqueer identity as "a unique little snowflake", "a big ball of mess", "a star in the night sky", "like a Martian" "off in a different universe", and, "a baby t-rex with hearts for eyes, like little cartoon hearts, with really sharp teeth, wanting to give you a hug, badly". The most common metaphor used to describe an individual's genderqueer identity was that of "genderqueer as freedom". Genderqueer identities were described as "freedom from trying to conform to any single gender expression", "freedom from having to try to explain myself", "freedom to be whatever you want without having to worry about gender specifications", and "freedom to dress certain ways, to be a masculine female and a feminine guy, and freedom to allow that expression to change over time".

4) Genderqueer strategies
      While genderqueer identity may begin with how a person feels inside, a clear component to the

identity of genderqueer experience appears to be related to how an individual alters their social body to match their identity. A number of strategies for acquiring a "genderqueer body" are as follows:

- gender neutral or stereotypically 'male' clothing on a body that is socially read as female;
- breast binding;
- testosterone therapy;
- "top surgery", which includes bilateral mastectomy and chest reconstruction;
- choosing a gender neutral name.

5) *Genderqueer visibility and pressure to "transition fully"*

The participants often made a conscious decision to "confuse", without concern for whether they "pass" as male or female. The individuals each reflected in different ways on how to make themselves "visible" as genderqueer, and spoke of a fear of their genderqueer identity being "invisible" to others. Despite marked concern about remaining "visible" as genderqueer, participants also related to the pressure from others to "transition fully" to a male gender role. Participants did not always experience others to be affirming of their genderqueer identities, but instead, felt like others were waiting for them to come out as transgender. Participants also struggled with being "trans" in a non-traditional way, particularly in light of the lack of resources or social recognition available for genderqueer individuals who do not wish to transition fully to a male identity but who also are not comfortable with their female bodies. There was a lack of therapeutic support and guidance for individuals who desired to transition to a genderqueer body; this "unchartered territory" was highlighted by a participant who discussed the experience of obtaining a letter for top surgery from a therapist, which was required to obtain gender transition related medical interventions. The participant felt that the use of binary language by the therapist ("the participant is a female who identifies as a male") did not accurately represent the participant's individual path.

Pilot Study Implications

The results of the pilot study helped to inform the development of the main study in several important ways. First, I was made aware of the diverse identities and experiences within the transmasculine community, and the different ways in which individuals experience and express their identities to others. I learned about various strategies for expressing gender identities, and the in-depth examination into the genderqueer community allowed me a more nuanced understanding of terminology frequently used. In the course of analyzing the pilot study data, I became curious about several gaps in the video journal data. First, I was curious about how these identities and strategies "played out" in medical and mental health settings and with health care providers; while pilot study participants touched upon this briefly, I was interested in exploring this further through the use of in-depth interviews. The individuals in the pilot study also shared several key demographic features in common (white, young adult/adolescent, educated). I was interested in how seeking individuals from the larger transmasculine community, including those from diverse ethnic/racial backgrounds, would explore transmasculinity differently. Finally, the results of the pilot study were focused primarily on how genderqueer (non-binary) transmasculine identities were expressed and experienced; I wanted to recruit members of the transmasculine community who *did* identify with the binary gender category of "male", or who did not make a conscious effort to appear "genderqueer", with the aim of exploring whether those with non-binary (genderqueer) vs. binary (male) identities have different access to and experience in receiving health and mental health care services.

Population/Sampling Method

Informed by the results of the pilot study, the population for this study consisted of individuals who identify their gender as transmasculine, and who have had at least one contact with a medical or mental health provider since the age of 18. A criterion-based sampling strategy (Creswell, 2007), which is a type of purposive sampling, was used to locate study participants. The initial inclusionary criteria for the study were, 1) the participant must have been born female (or, "assigned" female at birth) and 2) the participant must currently identify with a gender other than female. The determination of whether a participant met criteria to be interviewed was not based on diagnostic criteria for gender identity disorder or medical diagnosis of transsexualism; instead, participants self-identified as transmasculine. This allowed for a wider range of experiences and a more accurate view of transmasculinity than would have been achieved with a more restrictive sampling plan. In order to meet criteria for the study, participants must have been over the age of 18, English speaking, and able to provide written or verbal consent to participate. Excluded from this study were individuals who were born "male" and those who were assigned female at birth and still identified as "female". Also excluded were individuals who had never received health or mental health services. However, in order to participate, the individual only had to have had one interaction with a medical or mental health provider since the age of 18; they did not have to be actively receiving services at the time of the study. The purpose of this criterion was to account for those who may actively avoid medical and mental health providers due to negative experiences or perceived provider discrimination. Also, participants did not have to be medically transitioning (i.e., on hormones or having received chest/top surgery) to be eligible to participate. The purpose for this decision was because many transgender people may not have access to medical transition services, may not have transitioned "yet", or simply may not desire to alter their physical bodies, but still identify as transmasculine.

A core tenet of grounded theory method is the use of theoretical sampling, which is a strategy used in grounded theory to refine and elaborate on conceptual categories; in other words, it is an approach to choosing who you are going to interview or how your sample will be obtained (Creswell, 2007). Theoretical sampling techniques were used in this current study in two ways. I first conducted a pilot study focused solely on individuals who identified as "genderqueer", which is a smaller subsection of the transmasculine community. Participants in the pilot study would often mention themselves as "not trans" (i.e., different from other transmasculine identified individuals), or would discuss ways in which they differed from those who were born female but who identified in the binary category as "male". As a result, I aimed to include some individuals who identified as genderqueer or non-binary, and others who identified as male. My goal was to explore the different ways in which having a binary or non-binary identity may impact interactions with medical and mental health care providers and access to medical and mental health services. The assumption was that those who identified with a non-binary (neither male or female) category may have a different set of challenges in interacting with providers than those with "binary" identities or those who "appeared male", were "stealth", or who were not "out" to their providers as transgender.

Also, while I initially planned to focus on conducting in-person interviews in the San Francisco Bay Area, I received a number of responses from outside of the bay area requesting interviews to be conducted via web-cam/Skype or e-mail. In response to this suggestion from the community, I returned to the IRB to request permission to conduct interviews via Skype/web-cam with non-bay area participants. This allowed for a wider variety of responses and perspectives, and rich data in terms of how regional differences and community attitudes impact transmasculine identity development. While I

did consider that including those with access to an Internet/web-cam would result in a highly selective sample, it is worth noting that respondents with limited income and resources (one of whom was living in a SRO at the time of the interview) opted to participate via web-cam

While the goal of theoretical sampling in grounded theory research is to aid in "theoretical saturation" of categories, there is no rule for what an appropriate sample size for qualitative research is. However, in a review of grounded theory studies which sampled one hundred research articles from various disciplines, the average number of participants was 25 (Thomson, 2011). A separate review focusing solely on Ph.D. dissertations using qualitative approaches found that the mean sample size was 31 for all qualitative methods, and 32 for grounded theory specifically (Mason, 2010). Finally, in a study attempting to determine when "theoretical saturation" was achieved, Guest and colleagues (2006) analyzed their own data from a study of 60 women, and found that data saturation occurred early in the study: of 36 codes developed from their data, 34 were developed in the first 6 interviews, and all 36 codes emerged in the first 12 interviews. While these are simply examples of guidelines and not a prescription for an appropriate sample size, they provided a general sense that my sampling plan was appropriate and within normal limits of the theoretical and disciplinary traditions.

Sample Description

The sampling strategy outlined above yielded a final sample of 28 participants (13 in-person, and 15 via Skype). They ranged in age from 23 to 59 (mean age 34.4, SD=19.728). In terms of ethnicity, 20 (71.4 %) identified as white; three (10.7%) identified as black or African American; two (7.1%) identified as Latino, and one each (3.6%) were Native American, Asian Pacific Islander, and Other/don't know. The range of incomes varied from $0 per year to $70,000, with a mean income of $26,892 per year (SD=18,907.00). The education level of the participants also varied, with the range being from 12-22 years, with an average education of 15 years (SD=2). Twelve (42.9%) of the respondents were single, 13 (46.4%) were in a relationship or domestic partnership, two (7.1%) were legally married, and one did not report. Of the sample, 19 (67.9%) did not have children, while of the nine (32.1 %) who did, three were the biological parent of their child.

In terms of gender, 16 respondents identified with the binary category of "male"; other gender identity categories reported included genderqueer (n=4), trans (n=3), ftm (n=2), and one participant each indicating that they identified as masculine, transgender FTM, transqueer, transgender butch, transguy, transmale, and 'between male and female'; multiple participants (n= 8) described themselves with more than one gender category. The "legal gender" of the participants varied: 11 (39.3%) were legally male, 12 (42.9%) were legally female, and five (17.9%) were both male and female (depending upon the document). The sample reported a diverse range of responses in terms of sexual orientation: 12 (42.9%) identified as queer, five (17.9%) as heterosexual, three (10.7%) as bisexual, two each (7.1%) as "gay" or "pending", and one (3.6%) each another category (pansexual, fluid, lesbian, femmesensual). Please see Table 1 for a summary of participant demographic information.

With regard to medical transition status, 20 participants (71.4%) were on hormone therapy (testosterone) at the time of the study, and of those (n=8) who were not on testosterone, one planned to take it in the future, two did not, and five stated that they did not know if they would take it in the future. The number of years on testosterone ranged from 0-11, with a mean of 4.5 years (SD 3.5). With regard to top/chest surgery, fifteen had completed it, 12 had not, and one did not specify. Of those who had not had top surgery at the time of the interview, seven planned/wanted to have it in the future,

two did not, and three did not know. The number of years since top surgery ranged from 0 to 10, with the mean being 3.5 years (SD 3.3). Only a small number of participants (n=2) had any genital/bottom surgeries at the time of the interview.

In terms of health and mental health care, 21 participants had seen a therapist at least once since the age of 18, and nearly half of those (n=10) had sought therapy for reasons related to obtaining a letter to gain access to gender transition services. Of those receiving primary care, a majority (n=18) received care in private health care settings such as individual doctors' offices, physician group offices, or university health services. Six received primary health care in a public clinic, and one was receiving primary care services through the Veteran's Administration. Three participants did not have a primary care doctor at the time of the interview.

<div align="center">Data Collection Procedure</div>

Participant Recruitment

Institutional Review Board (IRB) approval was granted in March of 2011. After IRB approval was obtained, I placed paper recruitment materials (appendix A) in numerous locations frequented by members of the bay area transgender community, including The Pacific Center, University of California Berkeley GenEq Department, Mama Buzz Cafe, San Francisco Women's Building, and the White Horse bar in Oakland. Focusing recruitment on social/non-clinical settings was important, as I was interested in how transmasculine individuals outside of clinical settings were accessing and experiencing health and mental health care. The Internet was also key in recruiting members of the transmasculine community, and electronic calls for participants were posted on a number of transmasculine-focused Internet sites on facebook.com, youtube.com, the LGBT social work listserv and UC Berkeley "Queer Grads" mailing list. I also e-mailed the electronic call for participants to the leader of a Berkeley-based transmasculine support group, which I located on the Internet.

After the 'call for participants' flier was disseminated both electronically and in paper form, I received a total of 61 initial responses. Although I had set up a voice mail for participants who did not have access to email, all of the potential participants responded via e-mail. Of the 61 initial e-mail respondents, 25 were from within the San Francisco Bay Area, 30 were from outside of California, and six were from unknown locations. The initial e-mail responses often included brief inquiries, such as "can you send me more information about the study" or "I'm outside of the bay area, can you do interviews via Skype". For the bay area participants, I sent more information about the study and asked them to fill out and return a brief demographic screening questionnaire (appendix B), which was created to determine if the individual met the criteria to be interviewed. For the non-bay area participants, I informed them that while I was interested in hearing their perspectives, unfortunately the university approval was for in-person interviews only, and that I could not interview them at the time. Of the 25 bay area respondents that I sent the demographic questionnaire and more information about the study, nine never responded to a request to set up an interview, three were unable to be interviewed (one moved away, one did not show up for scheduled interview, and one canceled secondary to illness) and 13 participants agreed to be interviewed.

At that time, I returned to the IRB to request that the approval be extended to include individuals who were willing to participate via web-cam. Once IRB approval was obtained to complete interviews via Skype (in May 2011), I sent emails to each of the 30 non-bay area individuals who had initially expressed interest, to see if they were able to participate via Skype. Of these, 10 did not

respond to my e-mail, five responded back saying that they had no access to a web-cam, and 15 agreed to participate in an interview via Skype.

Interview Procedures

       Interviews were conducted between March and June, 2011. Once it was determined that an individual met criteria for the study, the interviews were arranged at a location of the participant's choice.   An interview room was made available on the campus of the University of California, Berkeley.   In-person interviews took place in cafes (n= 8), private homes (n=4) and in a research room provided by UC Berkeley (n=1). Online Skype interviews were conducted with 15 of the participants. I conducted the interview from my home, while participants "Skyped" from their own homes (n=11), offices (n=2), a public cafe (n= 1) and a Single Room Occupancy (n=1).   The main way in which the Skype interviews differed from the in-person interview is that Skype participants did not provide *signed* informed consent; however, as with the in-person interviews, I sent the participant a consent form (Appendix C) via e-mail prior to the interview, and reviewed all major components of the consent form verbally prior to turning on the recording device. After obtaining informed consent, I explained the general format of the interview, and asked them if they had any questions before the interview was started. I also obtained verbal consent to tape record the interviews, and informed the respondent of when I turned the tape recorder on or off. The participant was compensated with a $25 Trader Joe's gift card.

       I used the "general interview guide approach" (Patton, 2002), which provided more focus than an informal or conversational interview, but allowed for a degree of flexibility while ensuring that the same general areas of information were collected from each participant. The length of the in-person and Skype interviews combined ranged from 50 minutes to 140 minutes, with an average of 78 minutes per interview. The interview length did not appear to significantly differ between the in-person and Skype methods: the mean interview length of in-person interviews only was 76 minutes, (SD= 24 with a range of 50-140), while the mean interview length of the Skype interviews only was 80 minutes (SD= 16, range of 60-130 minutes).

Measures

In addition to data from the pilot study described above, the data in this study were derived from two primary sources:

Demographic Information: Information was collected regarding participants' age, ethnicity/race, current gender identity, current "legal" sex, current sexual orientation, relationship status, number of children, occupation, highest level of education completed, approximate yearly income, medical insurance status, and medical transition status. The demographic questions were all "fill-in", allowing for a greater range of responses than would have been yielded by using pre-defined categories, particularly for questions regarding gender identity and sexual orientation. Also, specifying that I was interested in *current* gender identity and *current* sexual orientation honored the possibility that participants may change their gender and sexuality during their life course, especially during a period of gender transition. Please see appendix D for a copy of the demographic questionnaire.

Table 1
Demographic Information

Name	Age	Ethnicity	Gender Identity	"Legal" Gender	Sexual Orientation	Relationship Status	Children	Income
Danny	36	Black	Genderqueer	Female	Queer	Single	yes	35,000
Drake	40	White	Transguy	Female	Femmesensual	Single	yes	0
Eden	23	White	Male	Female	Queer	In a relationship	no	12,000
Elias	32	White	Male	Male	Heterosexual	Single	no	35,000
Elliot	33	White	Transman	Male	Queer	Married	yes	18,000
G	36	Latino	TG Butch	Female	Queer	Engaged	no	0
Ira	29	White	FTM	Both	Queer	Single	no	34,000
Jace	24	Other	Transqueer	Both*	Pending	Single	no	0
Jacob	28	White	Transmale	Male	Queer	In a relationship	no	21,000
Jamil	40	Black	Masculine	Female	Queer	In a relationship	no	40,000
Jess	31	White	Male	Male	Gay	----	no	48,000
Kaden	42	White	Unknown	Female	Lesbian	In a relationship	yes	25,000
Kaleb	29	White	Trans and male	Female	Queer	Single	no	30,000
Liam	47	Native A	Male	Female	Bisexual	Married	yes	70,000
Lukas	29	White	Male	Both	Heterosexual	Engaged	no	25,000
Max	49	White	Male/Trans	Male	Bisexual	LTR	yes	60,000
Nathan	29	White	Male	Both	Gay	Single	no	30,000
Noel	38	White	Male	Female	Heterosexual	Married	yes	12,000
Nolan	38	White	Male	Male	Heterosexual	Single	no	16,000
Percy	24	Black	Male	Male	Heterosexual	In a relationship	yes	30,000
Rocco	59	White	Male	Female	Undecided	Single	yes	35,000
Ryder	28	White	Genderqueer	Female	Fluid/lesbian	Single	no	65,000
Samuel	27	White	Male	Both	Queer	Single	no	36,000
Sean	30	White	FTM	Male	Queer	Separated	no	0
Spencer	28	White	Genderqueer	Male	Queer	In a relationship	no	45,000
Terran	25	White	Male	Female	Bisexual	In a relationship	no	35,000
Thomas	30	API/Other	Genderqueer	Female	Pansexual/queer	Single	no	5,000
Zach	44	Latino	Male	Male	Queer	Married	no	6,000

*A legal gender of "both" indicates that participant is listed as "male" on some legal documents and "female" on others

Semi-structured Interview: Because of the nature of the research design, concepts were not operationalized or measured prior to data collection and analysis. However, the semi-structured interview schedule was focused on three main areas, each of which was developed to address different research questions. The first area focused on the participants' gender identity trajectory, and their path to defining themselves with a transmasculine gender identity. If it did not emerge naturally during the interview, participants were asked about how they learned about transgender people, as well as the best part of their gender identity and challenges that their identity has brought to them.

The second part of the interview focused on participants' experiences in receiving health and mental health care. In this part of the interview, participants were asked generally about their experiences receiving health and mental health services both related to their gender transition, as well as services not related to gender transition, such as gynecology, routine health care, emergency care, etc. The structure of the interview was dependent largely upon the participant's identity and transition status; if an individual did not have any interactions in seeking or receiving gender-related care, for example, the interview would focus mainly on experiences in receiving routine or emergency care. Because the participants experienced a wide range of services, each interview was structured differently depending on the participants' experiences. Each participant was also asked about their interactions and experiences with health insurance companies and for their thoughts in general about barriers that exist for people who identify as transmasculine.

The third area of the semi-structured interview focused on participants' interactions with health and mental health providers. Specifically, I asked participants to discuss the ways in which interactions with providers within the healthcare experiences discussed earlier in the interview changed or impacted the way that the individual thought about themselves in terms of their body, self-image, and identity. Participants were also asked about the importance of "coming out" to a provider as transmasculine, and were asked to describe the qualities that they look for in a health care provider. The semi-structured interview schedule can be found in appendix E.

To determine the appropriateness of the interview questions, the interview was "pilot tested" with two members of the transmasculine community with whom I was personally acquainted: an English professor, and a health care provider, both of whom identified as transmasculine. While the main interview questions did not change as a result of the pilot test, their feedback was helpful in the development of the demographic questionnaire. Specifically, the feedback from the pilot tests informed my decision to make all demographic information "open ended", to ask for "current" gender identity and sexual orientation (for reasons discussed above). The pilot test sparked a meaningful discussion about the "legal" aspects of gender, including what makes a person legally male or female, particularly when standards for documentation change (driver's license, birth certificate, social security card, passport, etc.) all differ according to the state in which one resides.

Data Management

Upon completion of the interview, the audio files were downloaded directly from the

recording device to a password protected laptop and were saved in an encrypted file format. Interviews were transcribed verbatim by the researcher, and all identifying information was removed from the transcription. Also, demographic data were entered into SPSS and participants were assigned a "participant number", which was used on the corresponding transcript to identify the participant. Follow-up interviews (n=4) were conducted via e-mail with the aim of clarifying or elaborating upon information that was not clear during the first round of interviews; responses to these follow-up questions were simply added to the end of the individual's data transcription. The interview transcriptions, demographic data, and transcripts from the pilot study were all uploaded into Atlas.ti, a computer program used for qualitative data analysis.

Data Analysis

Coding and Analysis Procedures

In their original text, Glaser & Strauss supported a flexible approach to grounded theory analysis, stating that "grounded theory can be presented either as a well-codified set of propositions or in a running theoretical discussion, using conceptual categories and their properties" (Glaser and Strauss, 1967). Subsequently, Strauss and Corbin (1998) outlined a more systematic way of analyzing the data in three stages that would result in grounded theory: open coding, axial coding, and selective coding. While there are multiple approaches to analyzing grounded theory data, for this current study I opted to use a flexible approach to analysis, focusing on the broad strategies of "pattern recognition" (Luker 2008) and thematic analysis (Auerbach & Silverstein, 2003), in order to allow ideas and processes to emerge organically from the data. Throughout the data analysis process, I used analytic memo-writing to help construct core ideas. Immediately following each interview, and throughout the data analysis process, analytic memo writing was useful in forging a link between the concrete data and more abstract theoretical thinking (Neuman & Kreuger, 2003).

I first examined the transcripts using open coding, or line-by-line analysis, and assigned codes to meaningful patterns in the data. The codes were assigned to segments of data (words, phrases, sentences, paragraphs) as appropriate. Sixty-eight codes in total were identified during the phase of "open coding". These codes were then divided into two main areas of inquiry:

a) codes related to transmasculine identity development (n=32)
b) codes related to experiences in receiving health and mental health care (n=36)

A full list of codes and their descriptions is presented in appendix F.

Identity Development Coding

Codes related to identity development were examined and organized using a "time ordered matrix", which has its columns arranged by time period, in sequence (Miles and Huberman, 1994). That is, I outlined a process of transmasculine identity development by presenting general stages that participants moved through in the time leading up to entering the healthcare system for the purpose of seeking gender related care. In this stage of analysis, codes were grouped into larger categories (for example, the codes "experiencing suicidality", "using drugs to cope", "problems with relationships" and "family" were all considered pre-transition

challenges). The codes involved in the final identity development matrix are presented in table 2, with each bullet point representing a code. Following the time-matrix coding and grouping the data to illuminate a general process of transmasculine identity development, I turned to the codes related to participant experiences in receiving health and medical care, as well as interactions with health care providers.

Coding health care experiences

The open coding process yielded a group of 36 codes related to experiences in receiving health and mental health care. Codes were then reduced and sub-codes were developed when appropriate. One example is the initial code "Seeking care", which initially included (43) instances in the data of participants discussing how they sought and accessed health care services. Using incident to incident comparison (Charmaz, 2006), "seeking care" was reduced into the following sub-codes: a) educating oneself prior to seeking care; b) relying on the LGBT community to access care; c) seeking queer/lesbian-friendly providers; d) use of the Internet; e) reliance upon support groups and networks d) avoiding care; and e) relying on self-management of health care. A similar technique was used to reduce a number of additional code categories that had substantial amounts of data. This stage of coding resulted in the final codes and sub-codes related to experiences in receiving care, which are displayed in Table 3.

Once this initial set of codes was reduced and refined, I examined the data for larger themes related to participants' experiences in receiving healthcare. In this stage of analysis, I stepped back from the descriptive nature of open-coding, and attempted to group the codes into larger analytical categories. The categories were then linked to each other to provide a conceptual model encompassing the various components of participants' experiences in receiving mental health and medical services. A number of patterns emerged during this process, and the data were grouped into five main themes which contributed to positive or negative experiences of receiving care:

1) Pathways to care
2)   Model of transgender care (standards of care vs. informed consent)
3) Organizational qualities
4) Health insurance coverage/policies
5) Provider qualities and communication with providers

During this stage of thematic analysis, it became clear that participants' *interactions with providers* and *provider qualities* could not be considered separate from participants' experiences in receiving care; that is, it was often *provider qualities* that determined whether a healthcare experience was positive or negative. Also, whether a healthcare experience was positive or negative often impacted an individual's sense of self-image with regard to gender identity. As a result of this discovery, I returned to the data one final time to explore how these main themes were related to one's sense of self/identity, by linking statements that participants made about how interacting with healthcare providers and systems impacted their sense of self as transmasculine. This stage of analysis resulted in the grouping of data into two main categories: *Identity affirming* experiences and *Identity Pathologizing* experiences. The final conceptual model resulting from this coding scheme is presented in Table 4.

Table 2

Identity Development Coding Matrix

Theme	Codes Used	total codes
Theme 1: Participants experienced/expressed childhood masculinity	• cultural components of gender shaped understanding about how gender was expressed • race/ethnicity impacted gender • regional aspects of queerness impacted gender • participants "feel male" or tomboy as a child	4
Theme 2: Participants "came out" as lesbian or gay (or accessed queer community) prior to realizing self to be transgender	• trying to be female for a period of time (expressing identity as "butch") • coming out queer/LGBT	2
Theme 3: Participants discovered that identifying as transmasculine was an option	• discover trans as an option (meeting a trans person, movies, online communities) • coming out-genderqueer • positive representations of transmasculinity • freedom	4
Theme 4: Participants defined personal understanding of "being trans"	**Pre-transition challenges**: • suicidality • using drugs and alcohol to cope • family relationships • romantic relationships • non-binary challenges • fear of transition • fear of disclosure • financial constraints **Deciding Factors** • importance of others recognizing as male • mismatch between presentation and ID • need for outside to match inside **Outcomes** • no medical transition • delay transition • undergo multiple steps of transition • bottom surgery	15
Theme 5: Participants experienced on-going identity development post-medical transition	• privilege of passing • realizing trans-positive impact • changing identity/sexuality • consider trans primary ID • don't consider trans primary ID • sexual practices change post-transition • trans visibility is important	7
	total codes	32

Table 3
Health Care Codes and Sub-codes

	Health care Codes and Sub-codes	
Code	Sub-codes	
Seeking Care	• educating self prior to seeking care • relied on LGBT community • sought queer friendly providers • lesbian-friendly (but not queer friendly) • Internet • support groups • avoid care • self-management of health problems	8
Gatekeeping	• gatekeeping • proving identity to providers • obtaining letters • pushed into binary • cost of therapy • informed consent • no counseling	7
Transgender Policies	• trans-friendly policies • intake forms • bathrooms • reception staff training • honoring name/pronoun • re-gendering as female • confidentiality concerns • questions about pregnancy/birth control • mismatch between gender and presentation • binary medical records	10
Health Insurance	• transgender insurance benefits • internal referral networks • denial of care • refusal to use insurance coverage • not being out to employee as trans	5
Providers	• coming out to providers • provider qualities • communication with providers • provider educating self • overt hostility/refusal to treat • misdiagnose mental disorder	6
Consequences of Care	• normalizing • validating • life-saving • health enhancing • stigmatizing • self-doubt causing • avoidance of care • fragile identity	8
	total codes:	36

Finally, using this proposed model, I explored whether these categories held true across different settings (primary care vs. specialist care), with different provider types (therapists vs. medical doctors), and with different subsets of the sample (binary vs. non-binary identities). I attempted to explore how well this model "fit" the data, and whether the categories were "saturated", which is a key component of grounded theory analysis. Saturation occurs when no new codes and categories are developed, and all data are accounted for in core categories (Charmaz, 2006).

Inter-rater reliability

I enlisted the help of a colleague from the field of education to code a subset of 3 interviews. The coder was given the final list of codes (appendix F) and was instructed to indicate for each interview whether the code was present or not present on an excel spreadsheet. These results were then compared to my codes for each interview to determine the level of agreement between the two coders. Inter-rater reliability was calculated using two different techniques. First, the "percentage agreement" method (Miles and Huberman, 1994) yielded an inter-coder reliability of 85%: of 66 instances of coding in the data across the three interviews, the coders agreed 56/66 times, and disagreed in 10/66 instances about the presence or absence of a code in the data. The percentage agreement method is computed as the sum of the agreed upon ratings (56) divided by the number of units being coded (66) = 85%. However, this method of calculation does not account for variability in the data (or, the potential that a yes/no answer regarding the presence of a code could be due to chance).

To address this, Cohen's Kappa (k) was used as an additional test of inter rater reliability. Cohen's Kapppa was chosen because it is appropriate for use with qualitative and categorical data. Using SPSS, Kappa was calculated and k=.667, (p<000). The general interpretation of Kappa is ≤0=poor, .01–.20=slight, .21–.40=fair, .41–.60=moderate, .61–.80=substantial, and .81–1=almost perfect (Landis & Koch, 1977). Therefore, the agreement for the initial coding in this dataset was considered an appropriate coding scheme once clarifications about discrepancies were made. Specifically, once inter-coder reliability was calculated, the disagreed upon items were flagged for further investigation. Two coding categories (*delay transition* and *educating providers about trans issues*) had more than one disagreement, and were placed under particular scrutiny. After discussing the discrepancies in the coding, it was determined that the coders were operationalizing "educating providers" differently: one coder was interpreting this code to mean that the patient/participant had to educate their provider about being transgender, and the other coder was interpreting it to mean that the provider received formal education about transgender issues. Similarly "delay transition" was interpreted by one coder as conscious steps participants took to NOT medically transition at all, and it was interpreted by another as "the time period prior to transition". To address these differences in the final stage of analysis, "educating providers" was clarified to mean interactions between patients and providers in which the patient took the role of educating the provider about what it means to be transgender, and "delay transition" was considered to be the time period prior to transition, a separate and distinct coding category from those who chose not to medically transition at all.

Protection of Human Subjects

This study recruited human subjects for the purpose of gathering information regarding

their experiences in receiving medical and mental health care services. All names have been changed and pseudonyms have been assigned to protect participants' confidentiality. Despite the strict adherence to ethical principles and practices, there are some potential concerns inherent in conducting research with members of the transgender community. For instance, many transpeople may "pass" full-time in a gender that does not match their biological sex, and may be reluctant to participate due to fear of being "outed" as transgender. Also, many transpeople have not gone through the process to *legally* change their names or genders, and may fear legal retaliation or suspension of social welfare services or benefits if they disclose information about their gender identity and legal status. This study addressed these concerns by strictly adhering to confidential practices that will not publicly connect any identifying information with any of the participants in the study. Also, to protect the privacy of participants, interviews were held in private, neutral locations agreed upon by the interviewer and the participant. Finally, participants were given the opportunity to decline to answer any questions and to only discuss topics with which they felt comfortable.

In this study, there was a slight risk of harm that a participant would incur as a result of participating in the interview process. Although stress may arise as a result of disclosure regarding gender identity and potentially negative experiences in receiving medical and mental health services, the participants were be clearly informed of their right to decline to answer any of the questions or to terminate the interview at any time. Another significant barrier in conducting research, particularly with members of vulnerable populations, is distrust of researchers (Loue, 1999). Because members of the transgender community have historically been subjected to the pathological lens of gender variance as a disorder, members of the trans community may be distrustful of researchers and therefore hesitant to participate in research. I attempted to address this barrier by consistent use of non-stigmatizing, trans-affirming language, as well as a non-pathologizing view of transgender identities. It was made clear to participants that the study did not aim to "treat" or "change" their identities, but to gather information regarding the experiences they have had within the health and mental health care systems. Also, because the recruitment occurred outside of clinical settings, the fear of participants being pathologized by the "medical model" of gender variance was likely diminished.

The purpose of this chapter was to provide an overview of this study's methodology. The next chapter will present the data, organized by the major themes that were uncovered during the process of data analysis.

Chapter 4: Results

This study sought to identify the process through which transmasculine individuals came to identify with a transmasculine gender identity. Also, the study aimed to understand how experiences in accessing and receiving healthcare services contributed to the gender identity development of transmasculine-identified individuals. In this chapter, the major themes and subthemes that emerged from the data analysis are presented. These themes are organized into two main sections: 1) themes related to gender identity development, and 2) themes related to participants' experiences in accessing and receiving health and mental health services, both related to gender transition as well as in primary or routine health care settings. Throughout the chapter, direct quotes from participants are used for added emphasis and to illustrate the theme. Following the discussion of identity and health care themes, a model of transgender-affirming healthcare is presented.

Transmasculine Identity Development Themes

A number of themes pertaining to the process of transmasculine identity development emerged during the data analysis process. These themes provide an overview of the main stages that participants moved through when discovering and developing their transmasculine identities.

Identity Theme 1: Experiencing childhood masculinity

When asked how they came to identify as transmasculine, an overwhelming majority of the participants (n= 25) began their personal narrative with a description of how they experienced masculinity during their childhood years. Participants described "always feeling male", "always being masculine", and "always feeling like a boy". When asked how they knew that they "felt" masculine or male, participants described how they their inner sense of masculinity was expressed through stereotypically masculine appearances, short haircuts, stereotypically masculine clothing choices, and disdain/hatred of stereotypically feminine attributes such as "wearing dresses". Liam recalled, *"It wasn't so much that I was doing this to be a boy, it was like, I just wanted to dress like that. And I think it wasn't that huge of an issue; it's like my mother sticks me in a dress…let me take it off and put on my pants and go on about my business".* Participants also preferred stereotypically masculine activities, such as "climbing trees", "playing in mud", and "playing football". A number of participants made sense of their childhood masculinity through self-comparison to male siblings: Drake stated, *"I was always into my brother's things, and wanting to dress like him, and be like him…and I had intense jealousy that he got to be a boy and I didn't".*

Despite experiencing feeling masculinity or maleness as a child, a majority of participants (n=24) did not necessarily experience severe body dysphoria or the desire to become "the opposite sex", which are diagnostic criteria for a diagnosis of gender identity disorder. Jacob recalled, *"I never woke up at three years old and thought, "I'm a boy." In fact, I was very comfortable in my female identity for many years".* Instead of focusing on the physical/genital/embodied aspects of being male, participants often defined themselves as "tomboys", a role which felt acceptable to many of the participants in this study. Max stated, *"I was able to be allowed to express myself any way, as I wanted, and in our society, females are*

allowed a much wider range of expression, and girls can have long hair or short hair, and, can be tomboys, and, boys aren't allowed to do that". Similarly, one participant's family not only accepted, but embraced his masculine gender expression, in the absence of a father figure or male role model in the home. G shared,

You know, it so happened that my interests, really were what were considered more masculine or boyish-type activities, and my ma is, um, being a single parent needed a, you know, masculine or boy person to take on certain roles like, taking out the garbage and washing the car, doing the yard. Now, my sisters were like, we're not doing that. So it fit into our family for me to take on certain roles and it just personally it felt like right and the way it was supposed to be.

Other participants used the descriptor "tomboy" as a default option, because they lacked the language available to make sense of the fact that they felt neither male nor female during childhood. Noel stated,

My journey started young, but I did not have the words for what it meant. I never quite fit in to the "boy" or "girl" space, but if I had to pick one side or the other my identity definitely fit more with the polar characteristics of "boy." So, I was called "tomboy" when I was younger.

Sean echoed this sentiment when he recalled,

*W*hen *I remember before I was 11 or 12, I don't remember identifying with a gender at all, I feel like, I was a quote unquote tomboy, if you looked at it from an outsider's perspective, and I never really felt like that's what I was, and I never felt like, either. In fifth grade they would separate the girls and the boys, and show the videos of what's going to happen in puberty, and I always remember sitting there, thinking, this is totally not me.*

Although participants identified themselves as "tomboys" as children, at the time that they were experiencing childhood masculinity, they did not necessarily want to *be* male during that time. As younger children, transmasculine individuals were able to express their masculinity freely, and sometimes with minimal discomfort or backlash from family members, peer groups, and others. It was during the developmental stage of puberty that many participants began to experience body dysphoria, which was precipitated by the constant "reminders" of having a female body, including the beginning of menstruation, the development of breasts and the widening of hips. In addition to the unwanted physical changes that accompanied puberty, participants were also challenged by constantly "being gendered" by others in society, including peers, parents, school-teachers, and even strangers who enforced the divide between males/masculinity and females/femininity. It was during this time that participants continued to explore different ways of being masculine within the confines of their female bodies, which was challenging in the absence of options outside of the mainstream binary of "male" and "female".

Identity Theme 2: "Coming out" as lesbian or queer prior to "coming out" as transmasculine

In addition to "feeling male" and expressing masculinity as children, a second theme that emerged as a core component of transmasculine identity development was that an overwhelming

majority of participants began to identify their sexuality as lesbian, gay, or queer in the absence of a culturally intelligible option for anything other than male or female gender categories. The development of queer identities occurred for most participants (n=22) when participants were in early puberty or during their teenage years, but also did not occur for others until later in life (n=3) or not at all (n=3). Participants initially began to identify with the lesbian/queer community as a way to express that they did not feel congruence between body development and masculine gender identity. In the absence of language to express this mismatch between body and identity, participants "came out" as queer as a way to begin to identify with a sexual minority group that offered a space for them to explore and express their masculinity. In light of attraction to women, Lukas stated, *"I just created this other life. I don't necessarily think I was unhappy, but I was just…I created this other person, and um, thought, "Okay, I'm a lesbian".* Noel echoed this sentiment, stating,

Eventually, I came to grips with being romantically attracted to girls which meant, at the time, that I must call myself "lesbian" so that others would understand. Sadly, I never related with the term "lesbian" because it is a feminine rooted term. It was easier for me to call myself "gay" although I really just felt straight (but, that was too difficult to make sense of!). I remained labeled "lesbian/gay" for 15 years.

Liam also expressed a lesbian identity as a way to define his attraction to women:

So let's see, um…I guess I came out of the closet, if you will... I couldn't deny that I had an attraction to women. So, I had to try doing the very butch, lesbian, dyke type thing. I hate being referred to as a lesbian, I was so not in that category.

Participants self-identified with the term "lesbian" in order to convey a non-heterosexual, queer identity to others, but simultaneously struggled with using a feminine-rooted term. For many, it "didn't accurately describe" their identities. In addition to espousing a lesbian identity as a way to express attraction toward women, a number of participants discussed "coming out as butch" (or, masculine lesbians), dressing in stereotypically masculine clothing, and expressing their masculinity intentionally in the context of a lesbian identity and the larger queer community. Drake recalled,

Not long after I came out as a lesbian, I still had long hair at that point, and although I dressed androgynous, and I got to a point where I decided I didn't like the clothes that I wore, I didn't like my hair, so I got my hair cut short, I started shopping in the men's department, which felt so liberating to embrace my masculine self

G also was able to express his masculine identity in the context of his participation in the queer community. He elaborated on the process of coming to identify his gender specifically as "butch", and intentionally separating this from an identity as "lesbian":

I was totally like intentionally building myself presentation-wise, as butch, but at some point I was like, "I don't think I'm a lesbian, because I don't think I am a woman. And to me, a lesbian is 2 women together. Well, I'm not a man because I'm not a male. And I don't want to be a male. Like there is no part of me that is like, 'I don't uh, I don't want a vagina and I want a penis

instead.'" You know, that was really when I started claiming butch as my gender.

In each of these accounts, participants were able to express their masculinity in the context of a queer "butch" identity, while the category of lesbian identity did not accurately capture their experience as individuals who disidentified with the category of "female". Jamil stated,

I thought I was lesbian, um, but, not only that, to be lesbian and to be butch or masculine on top of that, had it not been for my being able to be butch, I don't think I would have thought I was a lesbian for so long, because that was an option, to be...lesbian and be considered butch, so I kind of mistook that for a long period of time, but didn't enjoy certain aspects of it, I didn't enjoy sex, the way a lesbian would, I didn't, I tried...didn't like it at all.

Many participants remained in the lesbian/butch/queer identity for many years, and relied upon the queer community as a space to express their masculinity to others, including partners, friends, and family members. Not all participants felt uncomfortable in this identity category. Elliot reflected,

I came out as a dyke...and pretty quickly adopted a very butch persona in that, the history of that was very important to me. I felt very proud to be a queer woman, I felt, like a part of something as a butch. That was, and I engaged in the queer community, I engaged in lesbian spaces, and that was what I did, all of my friends were dykes, and I sort of had this radical separatist thing for a hot second.

It was not until the participants discovered the option to transition (socially and/or medically) to a male gender category that they were able to continue their journey of self-definition as transmasculine.

Identity Theme 3: Discovering the option to "be trans"

Transmasculine individuals in this sample learned about the option to express their gender as transmasculine in a number of ways. For many participants, "being trans" or transitioning gender from female to male was unheard of in the absence of any mainstream cultural representations of transmasculinity. Participants spoke of how television and other media representations of transgender women (male to female) did not reflect back an experience with which they could identify. It was not until a positive representation of transmasculinity was presented that the participant began to consider transmasculine identity as an option.

There were a number of ways that participants learned about the option to transition their gender from a female category to a male category. The most common way that participants discovered this option was through participation in the queer community, in which they interfaced with other transmen, and realized that medical transition was in fact an option.

Elliot*: And, at the end of college, I met a transperson, in real life, because at that point, although I was aware of trans people certainly, I had no personal contact with them. So, I met this guy, he*

happened to be the musical librarian at the college, and he was like, a normal person, which at the moment seemed like a revelation for me, that such a person was like, not crazy. Especially because whatever limited media access at that time, this was in the late 90s, so access was very limited to trans women, and usually in sensationalist forums, talk shows, or movies, whatever, where they're crazy, or dead, mostly. So this person was like, "wow, I'm a real person", and getting to know him, as an actual human being who was doing this thing in the middle of the Midwest, made it seem possible that I could also do...that thing. And so a couple of years later I decided that I wanted to transition.

Ryder: *It wasn't until after that that I actually became really good friends with an ftm, another ftm, and it was at that point, I was like, oh. There's this other...I had known about transgender people, I had known about gender identity, but until I became friends with a couple of people, it was like, OH. This is like, a thing, a real thing, and it's not...and things started to fall into place. That's what I am.*

Meeting other transmasculine people who reflected back to the participants a positive image of what it meant to be trans provided an opportunity for participants to explore the possibility of self-identifying in this way. A number of participants also learned about being transgender through other social relationships including through dating a female partner (as a lesbian) who was knowledgeable about transgender issues and brought them to the forefront of the relationship, and through attending college in a stereotypically "liberal" atmosphere (such as Smith, Oberlin, and Mills) where the queer community was visible and institutionally supported through queer student groups, social groups, and support groups for queer students.

In addition to discovering the option to be transmasculine through direct interactions with other transmen and the larger queer community, participants also learned about the option to develop a transmasculine identity through cultural and media representations of transmasculinity. Specifically, the film "Boys Don't Cry", which was released in 1998 and depicted the life and murder of Nebraska transman Brandon Teena, was frequently cited as the impetus for beginning to consider oneself transmasculine. Prior to the release of this film, there were no mainstream media depictions of a female-to-male transperson, and this film infused this option into the collective consciousness. Nolan recalled,

So on Boys Don't Cry I was able to see a man I could relate to, and I was finally able to figure out the terminology, to figure out what was going on with me, I wasn't stupid, I wasn't crazy, I finally had the terminology to express my identity.

Providing the terminology and validating one's experience as transmasculine were key components of the importance of watching this movie. During the same time period that Boys Don't Cry was released, the use of the Internet and engagement in online communities served as a common platform for participants to learn about the option to be trans. Involvement with LGBT/queer online communities was also key in the discovery of transmasculinity, and these venues offered participants a much-needed opportunity for identity exploration that was otherwise absent from the mainstream cultural milieu. Drake shared,

I started to become involved with butch/femme community online, and that community online

was where I started to read about transguys, read a lot of their posts, and hear a lot about their stories and their lives, and I realized that so much of their stories was my story too, about feeling the feelings that I had when I was a kid were the same, and the lack of being able to identify with women, not just feminine women, but even masculine women, I just recognized that there was something about transguys that I identified with, I did not identify with women in the same way.

It is important to mention that only one participant discovered and developed their transmasculine identity in the context of a relationship with a social services provider. In that instance, the participant was receiving treatment for severe depression and ongoing suicidal ideation. It was through interactions with this social worker who referred the participant to a gender specialist that prompted this change that the participant stated "saved his life". In all other instances, participants discovered the option to explore transmasculinity as a valid expression of gender identity long before they sought therapy or medical services related to gender dysphoria. This is important because it offers evidence to counter the mainstream view that Gender Identity Disorder is an individual, pathologized experience of identity. Instead, this lends support to the notion that it was not necessarily a pathologized sense of identity, or a severe sense of dysphoria or body hatred that prompted the desire to transition to a masculine-rooted gender category, but a shift in cultural understandings of masculinity and femininity where the possibility of transmasculinity presented itself as a valid option, particularly when participants interacted directly with other transmasculine individuals who reflected back positive images of transmasculinity. Through peer support, positive role models, and a larger queer/trans community (whether online or in-person), participants discovered that there were many different ways to experience and express transmasculine gender identities. After discovering the option to be transmasculine, participants began the process of defining, "what kind of trans person am I?"

Identity Theme 4: Deciding to transition

After they were exposed to a positive images of transmasculinity (either in person or through media outlets), participants began an individual journey of self-definition during which they explored what "being trans" meant to them. In this stage, participants began to contemplate, "what kind of trans person am I?", and began weighing the risks and benefits of the social, legal, medical, and financial components to transitioning from female to male. For Kaleb, *"it wasn't this sort of major epiphany of "Oh my god…" but more of like, "Huh. Let me see, what is that about?"* For a majority of participants it took several years between discovering the option to be trans and making a conscious decision to "come out" or present oneself as trans to others. Participants typically began this process by "trying on" a masculine or male identity role in the context of social relationships where it was safe to do so, such as with friends and romantic partners. This "social transition" process often included overt changes to gender presentation, by mechanisms such as cutting hair, wearing masculine clothing, and binding breasts. In this period of social transition, participants also frequently adopted a male name and asked others to use male or gender neutral pronouns. Stefan recalled,

So, slowly, it wasn't until like, early to mid-2007 that I fulltime identified as trans, even though I had been binding...and identifying more with genderqueer than as trans, and, it happened very gradually. I was trans for 2 years before I medically decided to do anything about it. Most of my

transition has been social. I really didn't like, come out, like, hey everybody I'm trans, it was very much trying to test the waters, and gradually getting more and more comfortable with my identity.

This was not an immediate or linear chain of events; instead, it was a long and complicated process of self-discovery and self-definition, which often took place over a period of years; another participant shared the process of what happened after he discovered the option to identify as transmasculine:

Nathan: *I realized at that point that I really did not identify as a woman. Um, I wasn't sure yet what I had identified as, and then over the course of the next 5 years, more or less, I don't know. The needle sort of moved more and more towards "man"…and I had finally decided that, well sort of that…um…it was worth the effort and risk of physically transitioning. Um, psychologically I mean it took me a while to realize that I could be a man without being like…super macho. Yeah, I spent about 5 years between that sort of realization that I WASN'T a woman, and deciding that I WAS a man. And yeah, identifying as gender queer, and genderly queer.*

Other participants had similar experiences of presenting and identifying in an "in between" stage prior to making the decision to transition medically. A majority of participants made the decision to delay their medical or legal transition after realizing themselves to be transmasculine, and chose not to "come out" for a variety of reasons. These reasons were related to the "cost" of being trans in relation not only to the financial burden of transition, but to the "cost" in terms of family, intimate relationships, and what it would mean with regard to membership in the larger queer women's community, where many participants had their social lives rooted for years. Participants often made the mindful decision to delay medical transition, instead choosing a number of other life paths. Jess recalled,

It was like, a waiting game, and I had made other choices, and it was like, well, do I choose, do I put my whole life on hold just so I can save money to have surgery, or, do I get an education, and start a job, and, do I move on with my adulthood in this way. And I had kept on choosing that I'm going to move on with other parts of my life, because I felt like it was more sustainable.

Participants also delayed medical transition based on relationships with their parents, partners, and children. Liam's decision to delay transition was related to his status as a parent, and not wanting to impact the children negatively:

Interviewer*: And what happened when you discovered the option to transition?*

Lin: *I said, I can't do that, I have children in the house. They're growing. I'm not gonna mess with their noodles. When they're 18, and out of the house, I'll explore taking T and doing surgeries and whatever I would do to actually change into a guy." It was completely off the table. I made that conscious decision sometime between 30 and 32 that doing the sex change just…while I would like it, and it would be cool to…There was just no way that I would do that to <my children> I mean it's tough enough for them now as adults to cope with it, I certainly wasn't*

gonna make them cope with that as kids. So that was off the table.

Another participant who also transitioned later in life, waited to transition as a result of having a son and due to concerns over child custody problems with the child's biological father:

Noam*: Back when I was putting off telling my son about my gender, another reason was my concern that his other dad, who was/is an angry bitter person, would try to use my gender identity and expression as a tool against me, even try to gain full custody of our son. So, our lack of respect and legal protection was an issue for me, if only temporarily. However, if my son had been much younger, this could have been a huge problem, as I may have had to wait many years rather than risk being taken to court and possibly losing him.*

In addition to parent/child relationships impacting an individual's decision to transition medically, participants who had romantic partners, significant others, or spouses at the time of beginning to develop their identities as transmasculine were faced with a particular challenge. As mentioned earlier, participants often identified as lesbian or queer prior to beginning the journey to transition to a masculine gender category. As such, participants who were in relationships with women who also identified as a queer/lesbian faced the possibility that their partners would not be comfortable dating a male or masculine person given their own identity as a lesbian. As such, the participants in this study would often weigh the costs of choosing their relationship over choosing to transition. This was often also a lengthy process where the participant had to weigh the "cost" of coming out/transitioning against potentially losing partners who did not want to "give up" her queer identity to be with someone who identified as male:

Terran*: I think it was something I was thinking about to myself, without even talking to my partner about it, for probably like, 6 months, it was something I was mulling over sadly in my head. Her concerns, she was very...she was vocal about her concerns, she was worried that my personality would change, and there's issues about her and her own identity, and she's identified as lesbian since she was 13, and went through a really tough experience growing up because of it, and she's having a hard time sort of figuring out how she wants to identify now and what level of disclosure we have with people.*

Other participants worried about how medical transition would impact their ability to form new relationships in the future, and how to disclose transgender status to potential partners who would read the participant as "male":

Jess*: Most of my anxiety about it was how my partners would react to it, and how, like...dating. And how to move on with a sexual relationship with somebody when you're not totally sure how you feel about your body, or how they feel about your body, and you don't know how to negotiate those connections because you feel like you're hiding something from people, there's something about living your life, I always felt like I was living, not like a lie, but like a secret. You know?*

Between the time they learned about being trans as an option, and making the conscious decision to either be "out" as trans or to weigh the benefits and costs of medical transition, a vast majority of participants (n=23) ultimately made the decision to medically transition through the use of hormones, surgery, or both. The main reason that participants opted to medically transition was not related necessarily to extreme body dysphoria, although this did play a role in

some cases; instead, it was the importance of others in society recognizing participants as male, not female, that was a significant deciding factor in this decision. There was a universal desire to be "treated the way I felt inside" (Elias), and for some participants, the "social transition" techniques discussed above were not enough to "pass" as male outside of their immediate social circles:

Jacob*: As I started to accept that I needed to make some more severe changes in order to feel better about myself and my body, I chose first to alter things like clothes and hair in an attempt to pass as male. After some time, it became apparent that I was not able to pass without medically transitioning. As I tried to pass and was unable, I became more convinced that this path was necessary for me.*

Another participant shared his reason for deciding to medically transition:

Terran*: Hmm....um, so, medically transitioning. I think that until I was able to start being perceived or read as male in the general world, it was really bothering me, and I definitely wasn't getting read as male before I started medically transitioning. and, it came up a lot for me at work in a way that was sort of distracting, because, me having to constantly think of what level of disclosure I wanted to have with people, and I didn't really want to be disclosing with, it was coming up in that way.*

For another participant, it was changing social role as a parent that precipitated the final decision to transition medically:

Noel*: My final decider for "coming out" as trans and medically transitioning was within the last year or two when I would discuss parenthood with my wife and our roles as potential "moms". We had been trying to get pregnant (her carrying) and I never related with the term "mom" or "mommy" or any version of when we would discuss our dreams as parents. Of all the roles I have had growing up (daughter, sister, aunt, etc.) the word "mom" bothered me most because it became more and more apparent that this would be a blatant lie to my child, the more clear my gender identity became. So, in the interest of being authentic and whole, I came out as "dad" in December 2010 and started my transition with hormones in March 2011.*

To achieve the goal of being perceived by others as male, participants used testosterone and top surgery to alter secondary sex characteristics and be "read" as male by members of society. While some of the participants did experience body dysphoria, this was not necessarily the most important deciding factor in whether or when to medically transition. Ultimately, the most common reason for choosing to medically transition was that participants desired an authentic experience in relationships with significant others, children, coworkers, and even strangers/larger society. Being "seen for who I am" was an important concept threaded throughout these narratives. This was also reflected in participants' accounts of how of their lives improved once they began medically transitioning:

Elias*: Um, I just feel like myself now. I don't feel like every day I have to try to be someone I'm not. It just feels really natural and I feel a lot more confident, and it's just...I dunno, it's like everything's aligned, and it's in the right place, where, my gender, or, my identity, uh, just like,*

*the perception of others, I'm fitting into what's more "normal" gender roles, or traditional gender roles. Instead of people trying to figure out what's wrong with me, or am I a man or a woman, like, **they're finally seeing me the way I feel**.*

Ira*: I don't have to answer for who I am anymore, because **people just see me as who I am**. There's no conflict between the way that I look and the way I act. And, you know, as fucked up as it is that we live in a world where people do have to have that kind of conflict, it's allowed me the freedom to just live my life without having to, at every step, explain myself to everybody else before I...you know, get this job or make friends or whatever. So, it's been kind of nice to just be able to just be a person, be who I am, and not have to answer for it, you know, if I don't choose to.*

Lukas*: I can go out in public now and not feel totally uncomfortable. I can walk and I always hated, you know, them looking at you - I don't have that stress anymore. I just don't have it. So it's been a benefit, and so that's always how you know you made the right decision, because if you're happier, you know, I just live in the moment and I'm so much happier.*

Elliot described his post-transition satisfaction/comfort in his body and in society in terms of the privilege that the mobility of his male body/identity afforded him. As opposed to feeling uncomfortable because he was not "being seen" for who he felt himself to be, he stated,

I feel comfortable in many spaces...I can be a straight white dude when I need to be, and I can be a queer fag when I want to be, and I can be something else when I need to be, and I can take advantages of the privileges of being recognized as a cis male, and not every transperson can do that, and I recognize that as a privilege.

While a number of participants had the desire to "pass" as male and to alter their physical, gendered characteristics to reflect a male identity, other participants felt comfortable presenting their gender to others in an "in-between space", and felt proud to challenge mainstream ideas about gender:

Ryder*: I feel a lot more comfortable, being...what I feel like being. I feel like when I was identifying as female, before I came out, it was, I was trying to be somebody. I felt like I needed to fit myself into certain stereotypes, but now it's like, being genderqueer, I don't feel I have to worry about that. But it just feels natural, and it feels like, I like the idea that people don't know what to do with me sometimes, it's good to make people question who you are, and who you can be, and I'm proud to do that. That's one of the reasons that I don't correct people, when they call me he or she, it's like what do you think I am.*

Although the decisions and paths about when, how, and whether to medically transition were varied and reflected highly individual trajectories, all of the participants recognized the importance of being their "authentic" selves, and allowing for that self-expression to be recognized and acknowledged by others, even when it deliberately confused them. The process of transmasculine identity development, however, did not end with physical transition. After transitioning to a male body/gender category both physically and socially, participants underwent an on-going process of self-definition that transcended embodied (physical) aspects of gender

identity and sexuality.

Identity Theme 5: Post-transition identity development/challenges

A majority of the existing models of transmasculinity do not address on-going identity development following social and medical transition. It is often assumed that once the body/physical aspects of transition are complete, that the gender identity development is complete, and that transgender men espouse a male identity. After making the decision to access medical services related to gender transition, participants in this sample experienced a number of positive impacts. They explained their post-transition feelings as "inner calm" (Max), "like 100 pounds had been lifted from my shoulders" (Zach), "like a dark cloud had lifted" (Ryder)   and "lifesaving" (Nolan). Physical transition, however, was not the endpoint to identity development for all of the participants in the study, but the beginning of a process of continued self-development and exploration. Ira reflected,

I mean, it's a transition. You don't just like go to sleep as a girl and then wake up as a guy. There's a certain element of learning how to be comfortable with yourself through the changes, learning, you now…There are differences in the way men and women socialize, you know, you have to sort of learn to negotiate your way in a world where first of all you're gonna be kind of in-between for a while, and that's going to be awkward, people are going to look at you weird, ask you what you are, not be sure whether to call you "sir" or "ma'am", you know…That part is tough, it's really hard, you need some support to get through that. And then just learning to just sort of be natural and the person who you really are, but are also in the process of becoming, you know.

Other participants felt limited by others' perceptions of what it means to be transmasculine, including that there are certain "right" ways to be transgender and that the trans narrative should include hatred of being/identifying as a woman. Participants in this sample challenged the assumption is that the transmasculine experience was rooted in a hatred of their female bodies and identities.   However, this was not always the case:

Samuel: *When I came out about my identity, there were people who were like, "Man, I bet you hated being a woman." And I'm like, "Actually, I didn't think it was that unpleasant - it just wasn't me." "Well, you have to have hated being a woman or else you can't be trans." "Um…actually, you can not mind being a woman but still identify as a man."*

Participants also battled assumptions of what it means to be "a man" or "a male", which typically equated maleness with the presence of a penis. Participants often considered the physical component of their transition "complete" after being on testosterone and completing top/chest surgery. Participants in the sample were less inclined to pursue bottom surgery, because, as one participant (G) shared, " *there is no part of me that is like, 'I don't want a vagina and I want a penis instead".* Another participant echoed this sentiment:

Nathan: *People get all kind of weirded out by the fact…that I wouldn't want a penis, or that I consider myself post-transition and I haven't had bottom surgery. And I'm like, "Maybe your penis matters a lot to you, but it doesn't really matter to me. Like I don't feel like I need to have a*

penis in order to identify as a man."

After transitioning to a male identity category, participants were still often faced with not being seen for how they identified: not necessarily as male or men, but as *transmen or transmasculine.* The "passing" as a cisgender male, for many participants, became an unwanted side effect of the medical transition, for those who felt "not female" but "not quite male" either. Jacob sheds light on this in the following excerpt:

When I was still being read as female, I felt as though I wasn't being "seen" for who I was. Now that I am passing as male, I still am not being seen for who I am, because I am typically being read as a cisgender, non-transgender, male, which disregards my history and my identity. People make assumptions about who I am, what I know, what I don't know, what I am capable of, and what I have in my pants - and most of these assumptions are usually false. In many situations, outing myself unfortunately doesn't make myself more "known" because of the lack of understanding about transition.

Although *being seen as male* by others was generally desired, participants frequently made a conscious effort to make their queer identities and ties to the queer community known after transitioning physically and "passing" as male. It was important to some participants not to "blend in" to heterosexual communities, but instead to *be seen as* trans, and validated as still belonging within the queer community:

Elliot**:** *I have to work a lot to make our queerness a visible part of our lives, so, to me, using the abolition transman as opposed to just man, is a way that I can recognize the specificity of that experience in myself. And also, to live OUT, which is an important thing to me, because, I, even though I pass, all the time, when I'm in a space where it's safe to do so, out myself, always. So, that's one way that I can do that.*

Terran: *I like to be active in the trans community and identifying as someone that's queer, not just, like, someone that I'm fading into hetero, or being, like, stealth, that's not something I'm interested in.*

Samuel**:** *I went from genderqueer to trans guy. I was a trans guy. I wasn't FTM, I wasn't whatever, I was a trans guy. And then identifying as a trans guy, I started saying, "Okay. I'm trans. Where do I want to go with my transition? Do I want to transition? How do I want people to see me? Am I comfortable with people thinking I'm male?" I wasn't really comfortable with that. And I'm still not really comfortable with the idea of being a "man", or being "male"… So I mostly, if people ask, I'll say I'm a male if it's kind of a forced choice, like "Are you male or female" I'm going to circle "male". But mostly I identify as just a guy.*

At the time of the interview, transmen in the sample had a diverse expression of transmasculine identity. While some claimed a gender descriptor of "trans" (i.e., transman, transguy, transmasculine, or transmale) others identified strictly as "male". Although the latter was the case for only a small minority of the participants in this sample, it is important to mention that variation does exist in the transmasculine community. Also, some participants who espoused a "male" identity during and immediately following the time of medical transition

experienced an identity shift years later. One participant who transitioned nearly a decade ago shared,

Danny: *As of late, I find myself thinking more along the third gender, or gender queer lines in terms of how I see my own gender. This of course is based on a variety of factors, included but not limited to: what the process of transitioning itself means to me, some of the biopsychosocial realities I have faced over the years, and a basic deconstruction of gender and socialization factors associated with it. Eight years ago, I never thought I'd be saying this but I see the benefits of living a more gender fluid life. It's as though I've come full circle in this quest to solidify my own gender.*

Participants discussed post-transition identity development in light of a changing interpretation and understanding of the difference between gender expression (how they present their gender to others) and gender identity (how they feel inside). Earlier in the gender transition process, it was crucial for participants to be seen by others as male, and many needed to transition physically in order for others to recognize them as male. Post-transition, some participants realized that they were dissatisfied with being seen as male and that blending in to heterosexual mainstream and not being acknowledged as "queer" was an unwanted side effect of medical transition. Liam shared,

Coming into my fourth or fifth year on T, I am starting to wonder if I would be happier going off T for a little while. I have started to lose my identity as a trans person and am blending in too much with the heterosexual male crowd. Most people, upon meeting me, assume that I am a heterosexual, cisgendered man. Men think it is okay to talk about women or LGBT people in demeaning ways to me. I don't want to be a part of that. I feel more identified with my more feminine aspects right now. I am trying to figure this all out.

Identity Theme Summary

The first set of themes which emerged in the course of this study serve a two-fold purpose. First, they add to our understanding about transmasculine identity development, while taking into account both individual and social factors contributing to identity development and decisions related to the choice to medically transition. Second, these themes help to serve as scaffolding for the second set of themes, which relate to participants' experiences in seeking and receiving health care services, including how these experiences may also impact transgender identity development.

Health Care Themes

As was highlighted in the first set of themes, viewing transmasculine identity as an individual, pathologized experience of identity (or, a mental disorder) does not adequately describe the myriad of factors that contribute to transmasculine identity development. While interpersonal and family relationships, social roles, educational background, ethnicity, socioeconomic status, individual understandings about gender, and access to a transgender/queer community all impacted one's gender transition trajectory, this current section explores how the process of seeking and receiving health care services may also impact transmasculine identity development. Specifically, this section will focus on how accessing and receiving health

services and interactions with healthcare providers and health systems may impact or shape a) decisions regarding whether and how to proceed with transition-related health care, and b) participants' self-image or perception of their transmasculine identity as a result of these interactions. Participants in early stages of medical transition must rely on medical and mental health providers to access services, and these experiences in accessing and receiving care can impact an individual's transition trajectory as well as their self-image as transmasculine. Similarly, interactions with health care providers, health systems and organizations, and the larger overall approach to health care provision in the United States may influence transmasculine identity development. While the aim of this research was to focus on participants' experiences across a full spectrum of care, most participants spoke about their experiences in accessing and receiving services in three distinct areas of care: a) hormone treatment, b) primary (PCP) care, and c) gynecology. As such, these themes pertain primarily to both transition related health care as well as primary/routine care and gynecological services. When relevant, examples from other settings (emergency care, specialist care) will be presented.

Healthcare Theme 1: Reliance on LGBT community when accessing services

Transmasculine participants in this sample accessed healthcare in a number of ways. Mostly, individuals relied heavily on the lesbian, gay, bisexual, and transgender (LGBT) community when seeking and accessing health care services. Prior to accessing care, participants often underwent a process of information seeking and educating oneself about available resources and "trans-friendly" health care providers. Participants defined "trans-friendly" care as health systems and individual health care providers who were both knowledgeable about and affirming of transgender health care. To gain information about how and where to access "trans-friendly" care, transmasculine individuals used peer support, direct word-of-mouth referrals, and online communities to determine which local area providers were able to meet their health care needs. An overwhelming majority of the participants (n=22) educated themselves about the processes, standards of care, and provider characteristics prior to seeking services related to medical transition. Participants typically entered into the health system having already sought the information necessary to undergo transition, due to the widespread community assumption that health care providers were not knowledgeable about transgender issues. Jess stated,

One thing that's really interesting about trans communities is that they're very, they tend to be, in my experience, kind of, I think they we take on the brunt of our own medical stuff. Like, we educate ourselves, first, because we know we might have to educate our doctors...so I think that's what unique about transpeople, is, we don't go in to medical situations being like, gee I hope this doctor can tell me what's wrong with me, or help me work through this process. It's kind of like, we do the work ourselves and within our community and we, like, move out into medical situations, to get our needs met, but not to be defined by what our providers see us as.

Participants sought and shared information with other transmasculine-identified community members prior to seeking care for transition related services. They asked questions of other transgender people who lived in their geographical area, and who had already received services related to transgender care. This information sharing took place either in-person or

though Internet communities. Participants also relied on relationships with peers to work through how to bring up transgender status to healthcare providers, including how and when to disclose transgender status to providers. Participants who lacked an in-person support network relied on the Internet for accessing information about finding trans-friendly resources and providers, using "word of mouth" via social networking sites (such as Facebook and YouTube) in learning about how to access transition resources. Other participants accessed information through online mailing lists geared specifically toward transmasculine-identified communities. Internet resources were particularly important for those living in rural areas or without access to a visible queer community. Nathan shared,

You know, I think the Internet is, you know, especially people who are in kind of isolated areas and who are just trying to figure things out, like I think it's wonderful that people could have that resource to explore and to just…type something into a search engine, where they don't have to sit down with somebody face to face and say, "I'm thinking about this huge issue," you know. It's such a non-threatening way to kind of dip your toe in or…you know, try the idea on and see how it feels, without a lot of personal risk, um… But I also think it's really very natural and helpful for people to have that resource that they can start with, in dealing with stuff that's just huge and scary, you know, particularly if you don't have a local community.

Participants also spoke of their own roles within the information sharing networks, emphasizing the importance not just of receiving information about trans-friendly health care, but sharing their experiences with other transguys, particularly with regard to how and when to seek transition related services. Jess shared,

I almost always refer trans young people to the public health care system, because, sometimes the care is actually better for transpeople, through the social services than through private doctors, I've found. So young people who have struggled more with their healthcare have been people who are going, they're going to the university's healthcare system, or, they're still on with their parents healthcare system, or they're seeing a doctor they saw when they were a kid, or, they're dealing with private physicians who don't have access to....they don't see as many trans people and they don't have as much experience.

Ira also shared his experience with starting a support group to share information with other transguys:

I think, well I ended up starting a support group for guys, because it took me so long to figure out. I was like, "Somebody needs to be like here handing out this information for whoever wants it. " So I kind of took it upon myself, because I spent so long figuring out all of the information, finally I had it all in one place, you know? Because one thing that I really found out about a lot of trans guys, myself included, is that…we tend to be I think really secretive with people, with other women, with trans women, with non-trans guys…for us to have our own space where we could talk and not feel, you know…ashamed.... So it's important to have that like safe ear space where you can just feel safe talking about whatever, and you're not on display, nobody's taking notes about you, nobody's saying, "Well, what was your relationship like with your father?" Like, you know, it's just like, you know, you're just…you're in the business of being a person and that's it.

Whenever possible, participants both received and offered support from the trans community prior to seeking care. In this process of information sharing, participants often identified a "go-to-person" in the community, or, a specific health provider or therapists who were considered by the local community to be "trans-friendly":

Jess**:** *I don't know why this is true, but for some reason, at the time, there were a few gender specific therapists and clinics in the nation, and one of them happened to be in Milwaukee, which was very close to where I lived. So, it wasn't, I didn't have struggle finding a therapist, cause there was already a go-to therapist that was like, churning out hormone letters, just like candy.*

Participants also sought services from providers affiliated with queer or LGBT health organizations, or from providers who were themselves openly Lesbian, Gay, Bisexual, or Transgender. Instead of using insurance referral networks or referral from social workers or other health providers, a number of participants shared that they *only* went to queer-identified providers because they perceived that LGBT providers shared an important commonality with them. Unfortunately, some participants seeking care from providers based on the provider's LGBT/Queer status found that although some providers had experience with lesbians and gay men, they were not necessarily equipped to work with individuals who identified as transmasculine. Participants discussed this gap between health providers being "LGB-friendly" and being queer or transgender friendly:

G**:** *Even though they're like, "I'm in this gay and lesbian…I'm working through this gay and lesbian center", they're still lacking in their general idea of queerness, of trans-ness being a part of queerness, and it's not just gay and lesbian, or gay, lesbian and bisexual, like…There's a whole undetermined number of sexualities and sexual expressions happening that can also go hand in hand with gender and trans status, you know. And so, it's not even a guarantee even though you're going through this queer center that you're going to have anybody find someone who has a working knowledge of queerness, you know.*

Kaleb**:** *Before I came out as trans I saw a lesbian identified therapist, um…who was great with lesbian stuff and not good with trans stuff. It made me really wary to talk about my own struggles in terms of gender stuff before I came out.*

Ryder: *There's a lot of people that have experience with lesbian communities, but, one of the, most amazing things about coming out, is that some of my lesbian friends in the lesbian community were some of the least supportive, so, it was this whole, you're betraying us, and, you're no longer a feminist because you're becoming male. So I don't want to go to somebody, like, I could look for someone who has experience with like, lesbians, but no, I'm not that. And I don't fit into the gay male category, that's something different all together.*

To summarize, a majority of participants educated themselves prior to seeking healthcare, particularly when it was care related to gender transition, and relied on peer support and the larger queer community when seeking and accessing care. However, even when participants attempted to access trans-friendly or affirming health services, they faced numerous barriers in accessing and receiving care with providers and organizations that failed to understand or

acknowledge transgender status.

Healthcare Theme 2: The model of transgender health care ('Standards of Care' vs. 'Informed Consent') was an important factor in participants' experiences of care

The participants seeking medical services related to gender transition (n=23) received care from providers and systems using one of two approaches to transgender health care provision. Fifteen participants accessed care through providers who followed the "Standards of Care" model set forth by the World Professional Association for Transgender Health (WPATH). In this approach, transmasculine individuals seeking medical services related to transition (including testosterone therapy and top/chest surgery) must first attend psychotherapy with a gender specialist or other mental health professional prior to accessing medical care. This therapist, who acts as a "gatekeeper" to the health services, must determine if the individual meets criteria for services using the DSM diagnosis for Gender Identity Disorder (GID). In this model, not only is it the responsibility of the therapist to diagnose the client with GID, but the therapist must document that the client has shown success in living in the opposite gender category through a real life experience, where the client must "prove" their motivation and potential for "success" as male. Should the therapist determine that the client meets criteria for services, the client is provided with a letter stating that they meet the diagnostic criteria for GID and are eligible to start hormone therapy and/or undergo surgical intervention related to transition. This letter is then provided by the transgender client to medical practitioners to gain access to medical services.

The mandate for transgender individuals to participate in psychotherapy yielded mixed results with regard to how this process impacted transgender identity development. Interestingly, participants' experiences with accessing services through a mental health "gatekeeper" differed depending on how they viewed their own transgender status. Those who viewed being transgender not as an identity category, but as a medical condition in need of treatment, experienced the gatekeeper as less of a barrier than those who considered their transmasculinity to be a social identity category. For those who viewed their transgender status as a medical problem, reliance upon medical and mental health providers to gain access to medical services was actually an affirming experience, because they were validated by being given a diagnosis for their disorder. Although this interpretation of transgender status as a medical problem occurred in a very small subset of the sample (n=2), it is important to note that not all participants experienced the presence of a mental health gatekeeper as an outright barrier to treatment.

For those who viewed transmasculinity not as a medical condition, per say, but as a social identity category, the mandate to participate in mental health treatment prior to gaining access to medical services was perceived as a barrier to accessing gender transition related health services. The most commonly cited challenge in receiving services through a mental health gatekeeper was that participants felt that they had to "prove" their identity to a provider. As a result, the interaction between the therapist and the transmasculine patient became less about the therapeutic relationship, and more about the patient constructing a narrative of distress and body dysphoria in order to meet criteria for gender identity disorder. This distress narrative, which was used with the main goal of obtaining "the letter", often conflicted with a person's actual experience of their body and identity. Transmasculine patients "took on" the narrative of body

hatred, gender dysphoria, and binary identity categories in order to access medical services related to transition. This process of "proving" their identity to a provider was often a pathologizing experience of transgender identity:

Elliot**:** *How do we prove this? I can't prove it, apparently, so, somebody with authority has to. And that, to me, is one of the fundamental problems with the whole "standards of care" model, and the fundamental idea that trans people are somehow sick, and require medical intervention as part of that sickness. We are denied the authority to speak on our own behalf. "I'm sick, so you shouldn't believe what I say. I'm crazy, how can you believe what I say" so that pathology denies me the ability to be my own agent, and the only people who can speak for the reality of my gender are people who have agency. And I'm not that. So, it's got to be, the doctor. And so that person gets to be a prover. And all of these letter producing bodies become real and believable whereas I myself am not capable of being a believable figure.*

The gatekeeping experience was also a challenge because participants felt restricted to rigid ideas about gender, masculinity, and being male in order to gain access to transition-related health services. Participants felt that they had to prove to providers that they were "trans enough", which left little room for true exploration of ambivalence or questions about certain aspects of transition. Participants also discussed how they felt pressure from the mental health gatekeeper therapist to present a very clear and specific type of masculinity:

Sean**:** *And I really felt pressured to, like, represent a very clear cut and concise picture, of, what I thought masculinity was. So I could prove to them that I was for real... so I felt like, I needed to be as...not ambivalent as possible, even if I had questions, that wouldn't necessarily reflect my intentions to not do this, but more like, my desire to be like, "I need to understand what I'm going to look like at the end of this", instead I was like, I don't want to ask questions of these guys because I don't want them to think I'm not serious about doing this. It was definitely like a gatekeeper feeling.*

Similarly, Ira shared how his therapist pushed him into a binary category of male:

My therapist had some very old school ideas, was totally not on board with gender queer at all, was like, "You either need to be a man or a woman". You know what I mean, like, and, so…When I went to see him I wasn't talking about, like, "How do you feel?"; it was like, "Did you cut your hair?" You know, I had like, this Strokes hair at the time, you know what I mean, like, "You need to get a haircut, you need to start wearing collared shirts"…And I was like, "Whatever. Whatever I need to do for you to tell me that you agree that I'm trans, and give me a letter, I'll do." Like, it was condescending but not exactly humiliating, I would say.

Another participant shared the experience of attempting to access transition services without the distress narrative. That is, he desired medical services to transition to male, but did not necessarily feel "dysphoria" or distress related to his female body.

Kaleb: *Um, basically all he <the therapist> wanted me to do was talk about me being trans. And so then I was like, "Well maybe in the first session he needs an overview of my life, and sort*

of learn how things are or whatever" but he was very…he kept asking about surgery. And then using language for my body that didn't feel very comfortable.... I let him know that my queer trans identities are the two stable, fulfilling things in my life.

In addition to viewing the need to prove one's identity within rigid and narrow definitions of masculinity and a narrative of trans identity rooted in pathology and distress, participants experienced the presence of a mental health gatekeeper as a barrier due to the high cost of psychotherapy. The length of therapy ranged from 3-6 months prior to the participant obtaining the letter, and this length depended largely upon how long the therapist deemed it necessary for the client to attend therapy, and not the participants' therapeutic goals or progress in treatment. For those who were without insurance who whose insurance companies excluded transgender care, paying out of pocket for long term therapy was a significant barrier.

Sean: *So I went to this woman, and she, you know, I told her what I was doing, and she was like, "you know, I think you need a lot of help, and we should probably meet at least twice a week for, like, 6 months, and I charge, $100 a visit, and I'd be willing to make a slight discount, you know, for your commitment, but whatever, and I came out of there, thinking, there's just no fucking way I can swing that.*

Jamil also shared his experience when he asked a therapist to provide a letter and was told that he would have to participate in months of on-going therapy:

I went to see him originally a year ago, asking him if he could write "the letter" for me, and I was really upset by his reaction. I guess he wanted to avoid litigiousness, and get me in therapy, for, whatever extended period of time that he would see fit for him writing it, and of course, that would be on my dime, and I didn't have that, and I really resent the fact that I have to ask permission, for somebody to say that I'm me, and that things aren't medically needed. Hey! Straight women can get their tits augmented, they can get lessened....but yeah, long story short, it really put a bad taste in my mouth... it's antagonistic, it's been a complete distaste for me. As far as how I see the medical field in general, as far as going and getting care? They're not...they're not friendly, they're foes.

Those who used their insurance to cover the high cost of psychotherapy faced a different set of challenges under the gatekeeper model. The purpose of the gatekeeper in the standards of care model is to make sure that the trans client meets eligibility for medical services. However, this function was often inadequate, because participants had to educate their providers about what it meant to be transgender. Because participants with health insurance had to receive services from an "in-network" provider, they often did not have a choice about where to go to receive services. As a result, a number of participants had to educate their providers about transgender issues while simultaneously relying upon the provider to grant them access to medical services:

Zach: *She had me go to the counseling department, um…and I had 3 sessions I believe with a social worker. The first one to tell her who I was and what I wanted and what it meant because she was completely clueless. Um, the second to give her information, I brought her pictures, and um…all kinds of information about the surgeons that I had been looking at, and the procedures,*

and um…and so she said, "Well, you seem very informed and like this is something you want to do."

With the burden being placed on the transgender patient to educate the provider, there was often no room for patients to truly explore the risks, benefits, and side effects, and potential consequences of gender-related medical treatments. Instead, the psychotherapy requirement was viewed as a barrier to those who had to both educate the provider about being transgender while "proving" their identity and eligibility for medical services. Although the Standards of Care model is the mainstream model that guides transgender health care provision, a number of participants (n= 8) received medical services (hormone treatment and/or top surgery) under a newly emerging treatment paradigm, also known as the "Informed Consent" model. The Informed Consent (IC) model was developed as an alternative to the mainstream SOC model, in response to a growing number of transgender patients and practitioners who view the role of the mental health gatekeeper as a barrier to receiving health care. In the IC model, therapy is considered an *option*, but not a requirement or prerequisite for access to hormones and surgical interventions. According to the IC model, a transgender individual should not have to PROVE gender or distress about identity; instead, they have to "possess the cognitive ability to make an informed decision about health care", including voicing an understanding of the risks, benefits, and information needed to make an informed decision about moving forward with medical services related to transition (Informed Consent for Access to Trans Health, n.d.). In the IC model, the trans patient must attend one appointment with a social worker or medical provider to discuss the social, financial, occupational, and familial aspects and consequences of receiving medical transition services and is granted access based primarily on the ability to consent to care. Participants who gained access to medical services under the IC model of care did so in a number of ways. Primarily, "trans-friendly" providers and transgender health organizations provided a space for potential patients to gain access to information about medical transition. This process did not involve "proving" gender status or masculinity; instead, it offered a space for the participant to receive information about potential risks and side effects of medical treatments. One participant attended a transgender health fair:

Jace: *I did not need a letter to get hormones from the doctor that I get hormones from. A couple of years ago we had a transgender health fair, here in Vegas, and it was a bunch of trans-friendly places in Vegas to get physical care and stuff like that, whether hormones, or you have the sniffles and to see if you have the flu or something like that, and so, the doctor that I go to, I didn't need a letter*

Another participant discussed how he participated in a two hour workshop that was led by a treating physician, where he and other transmasculine individuals who were seeking health services could ask questions of the provider and get answers.

Zach: *Well, I think that I received the best informed consent possible through a 2-hour T workshop. Like that, to me, was more than probably most people get, right, because it was all the fears and urban legend and myth kinds of ideas about what's going to happen once the T goes in the body, the doctor could just directly speak to everything from what it was going to do internally to what was going to happen externally to everything from behavior and mood and aggression to you know hair falling out and oily skin, sex drive, you know all the things that*

people wonder about, she was able to - not just with her medical experience - but with her medical experience specific to, at that point 12 or 13 years of experience with several trans patients, you know. So she was able to give us um…just a lot of anecdotal, so it wasn't textbook stuff she was giving us, she was giving us anecdotal, um… so it was better to hear it you know directly from the doctor who had all these different stories she could tell, and just the science behind it, um, so…that was informed consent, you know, cranked up.

Another participant also discussed his experience of attending a community "q & a" session with a treating physician:

Rocco*: I went to a discussion that was organized by the trans law center in San Francisco at the LGBT center with a medical doctor/physician…And she's a doctor at UCSF at the general hospital there, and um she did a two hour long Q & A about testosterone. It was fantastic because she basically just asked everybody, "What are your questions?" and she filled the chalkboard with everybody's questions, and when there were no more questions, she just started answering them. It was very very informative, very comprehensive, and her assistant at the time put up her name and phone number on the bulletin board if anybody wanted to make an appointment. And I immediately called that number, I made an appointment, and 30 days later I was on testosterone.* **I did not go through any counseling, I went right to the doctor.** *She used to work at - not Lyon Martin - she used to work at um…the one trans clinic you know that's down at the Public Health…um it's in the Civic Center, um…it's um…Tom Waddell. So she worked there for a number of years, and then moved over the UCSF General Hospital, so she had many many years of experience with trans patients. So she didn't require, she's a physician, not a…she's a family medicine doctor, not an endocrinologist, and she did not require the letter.*

Other IC organizations provide support groups as a place for trans patients to come together to explore medical treatment options and challenges with other transmen who have already been through medical transition:

Eden: *Wednesday nights, they do a group. so I went there, as opposed to paying for 1 on 1 therapy, so that was so perfect, cause what you're hearing is totally supportive...so that was my confidence builder. No...therapy. I went straight to Dimensions, and they were like, "are you a boy", and I was like, "yes!" and they were basically like, "you're good". So none of that...and then I saw my surgeon, and he was like, "have you had therapy, etc.", and I was like "no", and he was like, "but…you want to do this" and I was like, "absolutely". And he was like, you're good. So no, out of pocket therapy, I haven't had to do any of that.*

In addition to the group settings described above, participants who received care under the IC model discussed how instead of attending months of psychotherapy, they attended one individual session with a medical provider (doctor, nurse, or social worker) to discuss the risks and benefits of transition-related medical treatment. As opposed to a provider acting as a gatekeeper who determines whether the client would "meet criteria" for services, the role of the provider in this model was to determine *with* the client (and not *for* the client) whether they had the capacity to consent to medical transition services. This typically occurred when a participant sought care in an organization (Kaiser Permanente Health System, or publicly funded public health clinics) that had health professionals conduct an intake/assessment to determine the

client's capacity to consent. Often, after only 1 session, clients were then referred for hormone treatments:

Kaleb: *So that seemed to go really smoothly and pretty quickly, and I think there was maybe like a 45 minute meeting, and was given the okay. And in that session they offer ongoing counseling, but because I felt like I had a support network, it didn't feel like something I needed specifically around transition. Um and then I went to the medical side, had blood work drawn, and then came back I think the next week after I got my blood work drawn to go over the results and got my first shot. So things honestly moved really quickly for me in a lot of ways.*

Percy: *I found a doctor… He was a private practice doctor, was very much like, when HIV first became a thing, he was a gay doctor and was very much like treating HIV before, you know, regular healthcare was doing things like that. So, he and his staff were very compassionate, very caring. .. They started me on testosterone the first day I came there, you know like, gave me a squeeze on the shoulder, I mean, just really caring.*

Terran: *I was going through Kaiser, and I went in for a meeting with, they have a certain psychologist that they have people see for gender issues. I met with her once, to talk about where I was in the transition process, and she said, alright I feel you're ready to start now, if you're ready to start now you can go and do blood work and we'll get that done. So I got blood work that day, and the next day she sent me over to the injection clinic and had me do that. So it was way faster than I thought everything was going to be.*

Liam spoke about how the experience of not being mandated to participate in therapy was actually affirming to his identity as male:

Liam: *I went and saw the nurse practitioner, I sat down and we had a quick conversation…she said, "So let's finally put you on testosterone." And I was like, "Okay, so you're not going to send me out with some medicine for my head, right?" "No." "And do you have to have me go over to one of those rooms over there and have me talk to somebody for 5-6 months first, and we'll do it - I have to go use the guy's restroom, and we have to talk about how that feels…and all of this stuff, for a year, so that you can give me testosterone?" And she said, "No." And I was like, "Okay, I'm liking this place better and better." And um…I walked out with a prescription for testosterone, and they said, "Yeah, well, you're a guy." And I was like, "Yeah, thank you, okay, I KNOW this already! Thank you!" It actually felt really good to have gone in there and actually, "Wow, somebody actually gets this. Cool."*

Participants who received care under the informed consent model reported that not only did they not have to "prove" their identity to health care providers, but they were more able to engage in authentic dialogues about the expectations, risks, benefits, and side effects of potential treatments. Ultimately, the role of the provider was to exchange information and to assist the client with thinking through the decision, as opposed to determining the appropriateness of the client's gender identity and expression. The ease with which participants could access adequate services without needing "the letter" was both affirming to transgender identity as well as a cost effective way to provide medical transition related services, as paying for one session was more cost effective than paying out of pocket for 3-6 months of psychotherapy. As discussed earlier, a

majority of participants entered into the health care system as informed consumers, having already done a considerable amount of work to determine the risks and benefits of gender transition related care. These data provide preliminary evidence to support the IC model as a viable approach to transgender health care that provides both a more affirming and a more cost-effective experience than the traditional SOC/Gatekeeping model.

Healthcare Theme 3: Organizational qualities impact experience of care

A third theme that emerged with regard to transmasculine health care provision was that organizational approaches and policies pertaining to transgender health care were important in defining whether a healthcare experience was positive/affirming or negative/pathologizing to transmasculine identity development. A unique challenge reported by participants receiving health services was that there was often a "mismatch" between a participant's gender presentation, legal gender status, and gender identity, particularly in the early stages of medical transition. That is, prior to starting hormone treatment and/or receiving top surgery, participants still physically embodied female secondary characteristics despite identifying as male. Conversely, other participants "appeared male" due to hormone treatment/gender confirmation surgeries, but still had identification or insurance cards indicating a female gender. The organizational qualities characterized as *affirming* by participants were related to having their transgender status acknowledged and respected by health providers. Overall, participants who were able to use the name and pronouns of their choice (regardless of "legal" name or medical transition status) reported a more positive experience in receiving health services. Agency forms that allowed transmasculine patients to indicate both gender identity and assigned sex at birth were also useful in creating an organizational environment that was trans-friendly. For example, one health organization gave the options for participant to share both 'sex' category (M, F, and intersex), and also gender identity (M,F, FTM, MTF, Genderqueer, and OTHER-write in). From the perspective of the participant receiving health services in this organization, the mere presence of these options on health intake forms indicated to the participant that the providers had at least minimal training about or knowledge of trans health concerns, bodies, and identities. Other affirming organizational qualities included non-pathologizing assessment questions, prescriptions and medical records reflecting the participant's chosen name/gender, availability of gender neutral bathroom facilities, reception staff sensitivity about transgender issues, and decreased waiting room time.

The ability to communicate with providers prior to undergoing a physical exam was also helpful to participants in the sample, particularly when the examination involved a pap smear or a gynecological exam. Because transgender patients often presented as male but still required gynecology services, it was important to participants to be able to communicate with their health provider about transgender identity prior to participating in the physical exam. There were a number of participants who discussed receiving services in organizations whose policies allowed this to occur. One organization provided the option for patients to email their physician directly prior to meeting with the physician, which allowed the participant to disclose transgender status prior to the physical health exam. Similarly, another organization provided patients with the opportunity to speak directly with the provider before the exam, which is not always an option.

G recalled,

One nurse practitioner, she was pretty amazing. Actually, um… my girlfriend at the time - she was her, the person my girlfriend was seeing for her pap smears and all of that. And uh, and she had mentioned that you know she is in a current relationship and that her partner is trans and would she be even okay, like, does she have trans experience, experience with trans folks? And she was like, "No, but why don't you tell" - I'm sure she used 'her' - "we could meet. And we can have a sit-down, we can talk with each other before we actually participate in any examination." Right? And that was the first and only time that has happened. And she still didn't get it, but I definitely felt more confident and comfortable with her because I had a chance to talk with her and tell her, "Hey, I don't…If I do this with you, I don't want to have small talk, I don't want to sit, naked, at all. Like, when you come in I'll take off my boxers, we'll do the stirrup thing, and then as soon as that's done I'm gonna put my boxers back on." And she was like, "OK!" And I was like, "Oh, like, okay, okay!" You know?

Although the organizational qualities mentioned above had the ability to offer transmasculine patients an identity- affirming experience of health care, participants in the sample also faced numerous challenges when receiving services within health organizations. One of the most commonly discussed challenges faced by transmen in this sample was the need for services in a health organization that was considered a stereotypically "female space". Because most transmasculine patients still required ongoing gynecological care, particularly given the increased risk of cancer with testosterone usage, participants had to rely on women's health or gynecology practices to receive routine health services. One of the frequently reported challenges of seeking gynecology services in a women's health organization as a transgender male was that assessment questions were often geared toward non-transgender, heterosexual women, which was a source of discomfort for the transmasculine patient. Participants shared their experiences with feeling discomfort secondary to assessment questions that "re-gendered" them as female, despite transmasculine identity. G shared,

They ask, "Are you sexually active?" Yes. "Are you using birth control." Well, no. And then, immediately, the assumption is that I'm female, so I'm having sex and being penetrated by a penis in my vagina and it's unprotected so there's all of this risk involved with that, which is true, but that's not the type of sex I'm having. And, and, but they're already making that assumption. And so now I have to say, "Oh, you know, I don't have vaginal penetration by a penis," and some are like, "Huh? What do you mean? Like, how are you having sex then?" You know, and there's this….And nobody again has ever said that out loud, but like their facial expressions, their body language said this.

Spencer shared a similar experience:

Going to the doctor...What could possibly be uncomfortable about going to the doctor as a genderqueer person? <laughs> One, are you sure you're you? The nurse comes in to the waiting room, calling...<female name>? Blank stare as I walk over. Um, it says female? And I'm like, yep, that's me! Then the questions, "are you pregnant?", "are you sexually active", and "why are you not on birth control"? I said I have sex with vaginas! And there is NO way that I'm pregnant! They say, I'm concerned about your irregular periods...I'm all, hello, I've

already told you I've been taking testosterone for like 7 months. And no, I'm still not pregnant and I don't want birth control!

Questions about pregnancy were also difficult for other transmasculine patients:

Samuel: *When I had my top surgery, one of the nurses was like, "You need to do a pregnancy test." And I was like, "I'm not pregnant." "Well, you still need to do a pregnancy test, it's standard." Um…okay? And what's really interesting about that is that sometimes men who are taking testosterone can have a false pregnancy test. They can have a positive test even though…like…they have a penis and testicles, like they still can accidentally trigger the test based on other factors, prostate cancer or pre-prostate cancer can be an indicator if they have a false test. So I was like, "I don't know if they necessarily want me to take a pregnancy test because I know I'm not pregnant." So…good stuff like that. It's like, I shouldn't have to educate people that much about what it means to be trans.*

Another participant discussed his feelings in light of being "assumed heterosexual" during the health assessment process:

Jace: *I think the biggest like, I guess, issues would probably be having to answer the questions that they have, like, if you, like, if your organs happen to be female, like if you have female genitalia and they have to ask you all of those uncomfortable questions about so, are you having sex, have you been pregnant, and if you don't identify with that at least some of the time, that can be very uncomfortable because you're going, that's not really relevant to why I'm here…especially if that's not why you're there, if you're there for the sniffles and they're asking you how often you have a period, you're going, why are you asking that, that's really uncomfortable, and I don't identify that way right now.*

Participants also experienced challenges seeking services in a women's space due to the binary nature of computer systems and the use of electronic records. The use of "binary computer systems" or systems that only acknowledge the gender identity options of male and female posed a challenge for those in the sample that did not fit neatly into one of those categories. For example, participants who presented as or appeared "male" still had the need for routine gynecology/pap smears, and not prostate exams. Computer systems would provide "routine health screening updates" based solely on gender status, which did not meet the body or health needs of the patient. Max relayed,

Max: *Kaiser's computer system is still not...very smart about trans people. So on my little printout, on whatever their little reminder system is, wants me to have...um, it does not know when I need a pap smear, but does want me to have my "prostate" checked...so...I just don't think their computer system can handle it.*

In the absence of an option to indicate transgender status, these automated health care reminders can flag inappropriate health risks. Electronic records also posed a challenge for participants who changed their names or wanted to be addressed with a name other than their "legal" name or gender category. Also, if incorrect information became part of a medical record, it was difficult to have that information expunged from the record, amended, or changed. In the

case of transgender health care, the inclusion of incorrect information regarding gender transition status can result in inappropriate care. Samuel discussed his experience with this in the context of a health system that shared all records between other providers at a state level. When he disclosed his transgender status to a provider, the provider erroneously assumed that he was born male and was transitioning to female. Samuel stated,

Well it turns out that the way that the healthcare system works here in my town, that everything that you ever have done goes on to this electronic file that's shared by all of the physicians in the network. So, those discharge papers - they got corrected at the clinic, but they didn't get corrected in the system. And so later on when I went to another doctor, he had those same notes that said that I wasn't female, that I was male, that I wanted to be a girl, and I was on estrogen, and all this crap, and I was like, "Yeah, that's wrong." So now every time I go to another doctor for anything, like if I go for a dermatologist appointment, or if I go for whatever, they print out my medical history and the very top page is this completely terribly incorrect info. And so every single time I end up having to say, "This is wrong. These are the reasons why this is wrong. This is the truth." And so I ended up just typing all of it out and now I have a piece of paper that I just print out for every time I have a new doctor's appointment, and I bring it and I'm like "Replace that with this." And they won't do anything! They won't do anything to correct it! And I was just like, "This is so wrong! It's like, so wrong!" And I've actually run into that a lot.

Being incorrectly categorized with regard to gender transition status can have deleterious health effects and consequences. Further, the use of electronic medical records systems also poses a challenge because they may "out" a patient as transgender when it is not safe to do so. For example, participants who carefully choose a health provider or PCP based on extensive research and their status as "trans friendly" may be referred to specialists (i.e., a podiatrist, ear nose and throat specialist, etc.) within the medical system who are not trans-friendly, but the patient does not have the option to not disclose trans status because the electronic medical records are used system-wide. Not only does this pose a privacy concern, if specialists are not trans-friendly, they may act inappropriately toward the patient or refuse treatment based on transgender status. This knowledge may result in an avoidance of care, for fear of being discriminated against by medical providers:

Sean: *So, insurance-wise, ever since I started transitioning, I've been using public services or I've had insurance, and for the last 5 years, I've been working for a family practice, and I have great insurance through them, but I was, in the closet, and, they use electronic medical records, and on my plan, I'd have to see a provider who was in that network who used the same electronic record who was on my plan, and I was like, there's no fucking way I'm going to go to a doctor there and tell them anything. So, if I would have gone for anything, I kind of feel like I'm hyper-vigilant about my health, and I try to take care of myself so I don't have to go to the doctor, I've never been to the hospital, so the idea that I'd have to go to someone and even have the sniffles, and like have to divulge anything is like terrifying. So even when I've had insurance, I've gone to planned parenthood and have paid out of pocket to see her. And, I could afford it, I had a job, to pay the sliding scale...but I was like, I'm not going to go and educate another provider and have my shit out there, and have my coworkers seeing what I'm all about.*

The use of electronic records also calls into concern the importance of confidentiality with

transmasculine patients:

Nolan: *So, I had to have a surgical procedure with my sinuses, and when I went and got treatment with this doctor, he asked if I had previous surgeries, and I made the mistake of saying yes, and he asked why, and I told him, so he went and made a big show of crossing out my gender as male and changed my gender to female. And I told him I didn't want that in my file at all, my medical records at all, and he said it was necessary and I asked him why that was necessary because it has nothing to do with sinus passages. So he said it was only for him, he wouldn't tell anybody, however, when he wrote a letter to my medical doctor to go and tell how the procedure went, uh, he spent 3 sentences on the procedure, and a page and a half on how I was mentally imbalanced because I had an erroneous assumption that I was male and I was not, and that I was psychotic and had delusions and everything else.*

In summary, organizational approaches to transgender healthcare can have an impact on an individual's health seeking behaviors and their experience of receiving health care. Affirming experiences and "trans-friendly" care may increase continuity of care, and participants' willingness to engage in treatment and preventative medicine. Conversely, an absence of organizational policies addressing the challenges faced by transmasculine patients, particularly those who seek services in traditionally "female" spaces, may lead to a pathologizing experience of identity and avoidance of care.

Healthcare Theme 4: Health insurance policies impact quality of care

A fourth theme that emerged during the interviews was that health insurance status greatly impacted both quality of care and health seeking behaviors of transmasculine participants. This includes health insurance coverage and benefits which are provided to participants through employment, education, parents/spouse, or purchase of individual health plans. Health insurance companies in the context of this study were loosely defined as insurance organizations responsible for the provision of health benefits and authorization for access to health care services. While of a few participants (N=3), did not have medical insurance at the time of the interview, a majority of participants were insured through employment/school, their parents, partners, or other (VA benefits). Of those with health insurance, several respondents had insurance benefits through which the insurance carrier was also the health care provider or system (i.e., in the case of Kaiser Permanente health system, where the insurance is provided and managed through Kaiser and the health system is also Kaiser). Others received insurance coverage through enrollment in graduate school and received services at student health centers; those with individual plans or HMO/PPO plans through employment, parents, or partners, received care through individual health providers.

Overall, participants reported mixed results with regard to how interactions with their health insurance companies impacted identity development and gender transition trajectory. Participants whose health benefit plans allowed access to transgender health care and those whose health plans had an internal referral network appeared to have a more affirming experience of accessing care. For example, one participant who received services at Kaiser Permanente and had a benefit for transgender health services was able to negotiate through the system with ease by simply contacting the health system on the number on the insurance card

and asking who to see for transgender related concerns. The health system was able to inform the patient of which provider to see to gain access to necessary services, and the participant was able to clearly anticipate the requirements for accessing transition related care.

Other participants' interactions with health insurance companies did not increase access to care; in fact, for a number of participants, health insurance companies without transgender-friendly policies served as a barrier to accessing and receiving health services. A major challenge voiced by a number of participants in this sample was that their insurance companies denied primary or routine health care, based simply on the fact that they were listed as "male" on their insurance cards and were attempting to receive health services that are typically provided to female bodies (i.e., gynecology services, pap smears, mammograms, etc.). These services were often excluded from the benefits package, even when the care received was routine in nature and not related to gender transition. For example, Elias shared:

My most recent pap smear was rejected for coverage, and I had to pay it out of pocket because, I mean, they haven't billed me yet for it, but it said, "these services are for female patients only".

Denial of health care services was particularly problematic for those who had health benefits through their employers, but who were not "out" as transgender to their employer. As a result, when they signed up for health care benefits through their employment or spouse's employment, they were signed up as "male", and any health services that were classified as "female" services were denied based on their transgender status. Samuel recalled:

I am an "M" on my insurance, because my insurance was filed through Human Resources, because HR uses the gender listed on your ID when they fill out your paperwork. And so I am listed as an "M" and so they don't cover transgender care, like at all. So if I have anything dealing with my female parts happen, if I get I don't know, knock on wood, like some sort of cancer or growth or cyst, or if I just need a checkup, like all of that has to be out of pocket, like done at a free clinic, with a fake name like, because it can't get into that system that I have had gynecological care, because then they'll know that I'm trans. And then they'll kick back my prescriptions as being transgender related.

Participants also faced "exclusionary clauses" in their employer-issued benefits packages, which stated that the company would not pay for any care related to gender transition:

Terran: *I guess, let me tell you about my current, so my job now, I just started working for them full time, instead of part time, so I qualify for benefits, which is something I need...but they have a full exclusion for transgender care, so it's nothing, no mental health services, no nothing for any gender related services, which is really surprising, given that I work in the mental health field. It wouldn't cover hormones, and it wouldn't cover mental health services that would have any gender or sex diagnoses. So I'd have to go in stealth.*

As a result of exclusionary health insurance policies, a number of participants were unable to pay out of pocket for all health care, and as a result turned to public health organizations (Tom Waddell Clinic, Lyon Martin, Planned Parenthood) to access routine health services. Also, a majority of insurance companies did not pay for transgender-related surgeries (top surgery), so participants had to pay out of pocket for their services.

Healthcare Theme 5: Communication with providers impacted transmasculine identity development

The fifth theme that emerged from the data was that micro-level interactions and communication with health providers impacted participants' identity expression and development. When asked about their interactions with health care providers, participants defined providers as "trans-friendly" if they were knowledgeable about trans health concerns, used correct pronouns and name choice regardless of legal status, and expressed a basic understanding of the health needs of transgender patients. Being able to communicate with providers about transgender status was also important in terms of participants' experiences in receiving health care services. Disclosing transgender status, or "coming out" to providers, involved an exchange of information between the patient and the health provider where the patient made their transmasculine identity or status known to the provider and the provider acknowledged the identity expressed. A number of participants believed that disclosing transgender identity to providers was an important factor in receiving adequate medical care. For one participant, this was related to the importance of the provider having his full medical history in order to provide the best care:

Ryder: *For me, it's important (to come out) because…this is my doctor, they're there to help me take care of my body, but also, to help me take care of my mind, and if I need referrals for stuff like that, I want to be able to rely on her as a person I can go to and say, here's what I'm feeling, here's what's happening, what do I need to know. I feel like my doctor needs to have my whole medical history, mental and physical health, and if they don't have that, they're not going to be able to give me the best care.*

This interest in receiving the "best care" possible was also echoed in Jacob's reasoning for coming out to health providers:

I am not interested in hiding my trans identity from providers because I want the best healthcare I can get and I believe that this entails revealing my full health history, being trans is not just my identity but is also largely tied to my physical body and my health. If I felt unsafe coming out, I would rather leave the doctor's office than not come out. This coming out process feels extremely vulnerable, however, and the reactions of medical providers has the potential to make me feel very unsafe, especially if I am undressed or in an otherwise compromised situation.

Kaleb also mentioned the importance of receiving the best care:

I mean, I think that it is actually really important to come out to providers. In a lot of ways it's about being able to receive the best medical care, and the appropriate medical care, because at this point if I show up and people are trying to give me a prostate exam, that's actually not helpful because I don't have one. And so, and that's actually one of the main reasons that I've kept all of my documentation saying "female". And so if and when I do have health insurance, I want to make sure whatever I actually need for my body would be covered.

In addition to the importance of 'coming out' to medical providers as transgender, participants discussed the importance of the provider's *response* to their disclosure, particularly

with regard to how the response reflected positive or negative value judgments about what it means to be transgender. When the result of the disclosure was acceptance, validation, and respect on the part of the provider, the participant reported a more positive overall experience of receiving health care, particularly when seeking services related to gender transition. Trans-friendly/affirming provider qualities included open-mindedness, willingness to learn about the patient's health care needs, and not pretending to know everything about transgenderism. These providers were able to communicate with the patient about what they knew and did not know about transgender health care, and, in the absence of evidence-based knowledge about transgender health care, were willing to seek information and do research to ensure that the services provided to the patient were adequate. Jace discussed how the provider taking an active role in self-education was important in his experience of health care:

Jace: *I would like healthcare providers to be open minded and actually willing to learn, because on one level, there aren't enough knowledgeable healthcare people that know about transgender issues, if you're willing to learn, I'll overlook that, if you know something, and you know people that are more knowledgeable and you contact those people, I'm ok with that, because that shows that you're open minded and you're willing to help me as a person and not as a gender.*

For another participant, the fact that the provider was seeking information about transgender health issues gave him confidence that he was receiving competent care:

Nathan: *My primary care physician that I WAS seeing, she was much more like, "Well I want to consult with somebody who knows what they're doing with this, you know, so that I know I'm giving you the right prescription" and, you know, that kind of stuff. And even though I didn't always have the answers for her, like, just the fact that she was seeking the information herself, gave me a lot more confidence that I was getting competent care.*

The providers taking a collaborative approach with the patients, recognizing diversity in the transgender experience, and asking questions of the patients about their experiences with being transgender were also important contributing factors to positive experiences in health care. Also, providers communicating with and trusting the transgender patients to collaborate with the provider was important as well:

Samuel: *My doctor will send me email links to different articles that he's found online about this condition, that condition, this drug that drug, things like that, like just…I know that he is reading and that he's talking to people and that he's doing research. And that comes out in our conversations. The doctor taking a minute to step out of their comfort zone and say, "Okay, I don't know everything, but I'm going to go do some research and then I'm going to see where that research connects with you. We need to work on this together."*

Participants discussed how interactions with health providers positively impacted transmasculine identity development in terms of how they viewed their transmasculine identities and bodies. When providers were affirming in response to transgender disclosure, participants described the experience as validating, confidence building, normalizing, and helpful; this resulted in patients feeling that they could make informed decisions about their transition and that they had the support needed to move forward. Providers who were supportive of transition

also positively impacted a patient's self-esteem and overall well-being. For example, as a result of an affirming relationship with a health care provider, Nolan stated, "*I really went and changed my own personal outlook on my body, myself, and they taught me how to feel hope for the first time ever in my life*". Kaden relayed, "*I felt that I wasn't crazy, that there was something to this*". For Sean, feeling like the provider cared about him as a whole person (and not just a disorder), prompted him to take better care of his body and health:

Sean: *When I started seeing a provider who reflected back positive images of me, I started caring about what I was reflecting to her. She's like, oh, you look great, but, how are things? How are you doing? Are you smoking? Are you exercising? So...it's a little bit more, I feel like the way I imagine people ought to feel when they go to the doctor, which is, they feel like a whole person, instead of a specific disorder.*

Interactions with providers who were respectful of transgender status were particularly important for transmasculine patients who were in early stages of gender transition, because they often sought validation from providers about their decision to move forward with transition:

Terran: *I think initially my interaction with the doctor, it was helpful, it felt very validating as far as my identity as trans, and it felt good to tell my parents, like, well, this was agreed with by a professional. When I described to her my life experience, she thought that I was "trans enough", it was nice to have that level of validation and, as far as working with the general practitioner, it's nice to just, it was the first time that people I hadn't met before were using male pronouns with me and that was a very positive experience.*

For one participant, a provider was the *first* person to validate a his transmasculine identity, and it gave him the fortitude to move forward with his medical transition:

Lukas: *To me, having him say "male" this that, "how you doing bud", and using that kind of masculine terminology helped me form who I was in my head, because someone else was saying it out loud.*

For others, having transmasculine status acknowledged by health providers was both confidence-building and normalizing:

Eden: *They definitely gave me confidence, because I was able to go in there, no therapy or anything, just saying something and having it affirmed, like male pronouns, even pre-T, so that, my interactions with that clinic was probably all it took, that's all the confidence I needed, and then I got started.   But my experience with healthcare is having someone right initially who gets it was all I needed to know that it was safe, to do it, like, it was fine. My experience with my doctor was amazing, he was great, used male pronouns, just made it very, he made it very, like, normal seeming… he made it very matter of fact.*

Jess: *Having access to someone like that who actually gets it, having access to someone who does understand those things, is really confidence building, or self-esteem building, because if you leave talking with them thinking, ok, cool. I'm not weird for feeling this way, there's someone there who gets it…I've had a relatively smooth process getting hormones and stuff like that, and*

having that kind of process for me is even better, because I don't feel like I'm as weird as other people are thinking that I am.

Just as communication with providers, provider education, and providers' willingness to learn about transgender health concerns were all key aspects of positive and affirming experiences of health care, transmasculine individuals in the sample relayed a number of negative, or identity pathologizing experiences that emerged through interactions with health care providers. Some participants reported that the providers were "giggly", "unprofessional", "confused" or "shocked" upon finding out about their transgender status. Others reported that their health provider showed "disgust", "discomfort" and felt they were being seen as "a freak show". Perhaps the most damaging of these experiences was when providers exhibited overt hostility toward a patient based on the patient's disclosure of transgender status. This transphobia or hostility was evident in a number of instances. One participant recalled being hung up on by a provider whom he contacted seeking services:

Samuel: *I guess the most negative experience I had with doctors was when I was first trying to find doctors who would prescribe testosterone. So I called the health center at the university that I was trying to get into, and I said, "Hello, I'm an incoming student, um…and I'm interested in finding somebody who will monitor my testosterone, because I'm a transgender male…And the person on the phone, the receptionist or whatever, was like, "Um, we don't do that sort of testing here." CLICK. "We don't do that sort of service here." CLICK. And I was so upset about that. I was like, "Why, you know…the one, the phone call that was going to make me feel comfortable calling other people, the first time I actually said to someone outside of my support circle that 'yes, I want to start testosterone' and she hangs up the phone." And that kind of, that definitely colored all of the other doctors that I called.*

A number of participants also discussed how overt transphobia manifested itself during interactions with health providers, both through verbal communication with providers as well as during physical examinations. For a number of participants, these interactions occurred during the gynecological exam, when the patient was partially undressed and in an extremely vulnerable position. Kaleb shared,

I went to the Clinic, and the practitioner that I had was actually really awful. While she was doing the pelvic exam she was grilling me about trans stuff, and about the effect of hormones and what happens with your pH levels, but was kind of like yelling at me. And it's all this stuff that I don't know, you know, about the long term effects of testosterone. I tried to explain that actually, nobody really knows that. She's like batting down the sheet between my knees to like make eye contact and yell at me, essentially, for not having information. And then implied that I had multiple STIs that, it turned out I didn't, everything came back negative and so I really think all of that was coming from a transphobic place. So I think it was around transphobia, it was around the how to handle me, it was around queerness, there was like, a lot happening. It was really awful.

Another participant relayed a similar experience with provider hostility in response to disclosure of his transgender status:

Zach: *My first time there I was there just to establish myself with them in their system. I was sitting in a chair, and the doctor…she stood up, straight across from me, and just started to grill me with questions like, "Why are you taking steroids" and "Do you know what it's going to do to your body?" and "You're going to have a heart attack and your cholesterol is going to go through the roof" and "Why are you in this clinic, why did you come here?" How are you even eligible for these services?" I was just like, "Wow…. if you have a problem with what I'm doing, then maybe you shouldn't be the person in the room with me."*

Lukas experienced a similar line of questioning about the side effects of testosterone while undergoing a physical examination:

Lukas. P: Well I had…you have to do a gynecological exam. Anyway, not that I want to talk about this, but you're in that position, and she looks up and was like, "You know you're going to bald, right? You know you're going to go bald, right?" And so I'm like, "This is just the most awkward moment in my life probably, and you're going to say this to me in the middle of this…YES I fucking know." So, that's as uncomfortable as I was, and you know, that was a weird, weird thing to say. I was kind of like, "What?!"

In addition to provider hostility as a response to the patient disclosing transgender status, participants also experienced distress as a result of providers not honoring the patient's name or pronoun choice. This occurred most often in early stages of transition, particularly when participants had an insurance card, identification, or outward gender expression that did not match their chosen identity category:

Thomas: *I've given up, they will not understand the pronoun issue. So, um, I got there and I was like, I'm transgender, I go by he, and the director of the department, said, "well, he, she, it doesn't matter, to us you're just a person to us".   But that's really, before when I just started to transition, it was triggering for me to be assertive about my pronoun, to ask people to call me he, especially in front of other patients, and to be told no, because my card says F.   "we have to call you F if your card says F". So the fact that, even when requested not changing, that is really disrespectful, actually. There's not the mindset that people need to be respected.*

Lukas also discussed his experience with not having his pronoun choice honored by his doctor:

And you know, the lady who I went to, she wouldn't say "him" - and actually she slipped up a lot and said "she". And that's tough, and you're trying to work it out and like live with this life, and you have someone blasting you back, you know. You know. So using the right terminology is a huge opportunity for medical professionals to not harm their patients, because you can harm them by saying the wrong pronoun and not… for the person hearing it, you're just reinforcing a negative thing for them.

In addition to participants' experiencing challenges with providers not honoring their transgender statuses and insisting upon referring to them as female, one participant discussed his experience in seeking sexual health services with a doctor who had never had a transmasculine patient before, which resulted in the doctor ultimately refusing to examine the patient:

Jess: *When I saw the physician, I said, I'm here because someone I'm having sex with is having symptoms, I need to be treated, or whatever, for STDS. And she was like, 'what do you want me to do' and I was like, 'uh, I'm no doctor, lady, I don't know what to tell you". And she said, "well, if you were a woman I would have you lay out on the table, and if you were a man I would just have you stand there, but I don't know what you want me to do". And I said, I don't know what kind of information you need, from my body, so I don't know how to tell you what you should be telling me to do. And she just said, hold on a second. And she left, and she came back, and she just gave me a prescription and said, here, take this.*

Provider misunderstanding or misconceptions about being transgender also biased the interactions that transmasculine patients had during interactions with providers. Upon disclosing transgender status to providers, a number of patients in the sample were labeled as mentally ill, and treated with psychopharmacological interventions for depression or other major mental health disorders. Nolan discussed how he was misdiagnosed with multiple mental health disorders over a number of years:

The misdiagnoses were bipolar disorder, I was also misdiagnosed as schizoaffective, schizophrenic, BPD, back to schizophrenic, Bipolar type 2, major depression, back to schizophrenic, it was a personal favorite of theirs…I've been on every psychotropic drug known to human kind that was available at the time, including antipsychotics like Thorazine, experimental stuff, they wanted to do ECT on me, the gamut. And none of them worked because I wasn't mentally ill.

It was also problematic for providers to view being transgender as an illness or a disorder, particularly when that was not how the participant viewed their own identity. Ira shared,

The endocrinologist that I ended up seeing, she kept referring to it, my being transgender, as my illness and my disorder, and I was like… and I didn't really have the words to like, understand or explain to her why like, it's not…but I was like…I'm not like coughing, like, I'm fine, I need help being more fine, you know. And, it was just very degrading. They were telling me I was ill, you know, they had to make sure it wasn't schizophrenia or something… that almost made me be just like, "Forget it, I can't do it." You know, because you know, you have so much riding on it, you need it like so bad, and if somebody throws like one little road block in your way it's, it can be enough to totally undo you, you know what I mean? Especially, if they're mean to you about it, you know?!

Providers equating transgender status with mental illness, in one instance resulted in the medical provider refusing to treat a patient for a breast lump:

Drake: *I got turned away from a physician's office for, some sort of a lump or something in one of my breasts. I was pre-top surgery and went to a physician about it, and the doctor was like, "You know you kind of did this to yourself by binding, and I'm not going to treat you because it's your fault you have this problem, like you have this, you know, mental problem that's making you do these things."*

These negative interactions with providers in response to disclosure of transgender status

had the potential to send pathologizing messages to patients about their transmasculine identities and may affect their decisions to pursue medical transition. Participants were asked about how negative or pathologizing interactions with providers impacted their path to transition, and they reported that hostile interactions with providers or being mislabeled as mentally ill caused them to feel stigmatized, embarrassed, doubtful about transition, and caused an increase in gender/body dysphoria. These interactions also prompted some participants to avoid receiving health care completely, despite the potentially life threatening consequences of doing so. Ira stated,

I have really serious kidney problems, and I need, I should've gotten them dealt with a lot sooner, and I mean, this is stuff that could kill me, and very well might…And honestly, I've been putting it off, I'd say 30% because of just how the trauma and knowing it's going to hurt a lot and being really traumatized by previous treatments, but probably 70% because I'm trans, and because I'm going to have to take my pants off in front of doctors, and have things put in me and things like that, you know. And I just, I'm afraid of what it's gonna be like. So, um…If…I would say that if I felt that in general any healthcare provider you went to is going to be compassionate and knowledgeable about trans issues, then I would have sought help for this a long time ago.

Micro-level interactions with providers, particularly regarding disclosure of transgender status, were a key component in participants' experiences in receiving healthcare. Overall, these interactions had an impact on how the individual chose to move forward with gender transition, and also how they viewed their own status as transgender. Providers who reflected positive responses, engaged in meaningful dialogue, and educated themselves about transgenderism were affirming to participants' transmasculine identities. Conversely, providers who were hostile or who mislabeled being transgender as a mental illness had the potential to cause harm to trans patients by pathologizing their identities, which, in some cases, resulted in the avoidance of the health care system.

Model of Transmasculine Healthcare Provision

While transgenderism is often framed as a pathologized or disordered experience of identity, many transmasculine individuals do not feel distress due to their transgender status, but over how they are treated by others as a result of their identity and gender expression. The results of this study indicate that health professionals, organizations, and systems have the potential to add to this level of distress or detract from it, depending on a number of components involved in seeking and receiving health care services. These components include: pathways to care, model of transgender health provision (standards of care vs. informed consent), organizational approaches to transgender care, health insurance policies, and communication with providers. These components have each been identified as key to transmasculine patients' experiences in receiving health care services. Each of these components of care have the potential to impact identity development positively (by offering an affirming or "trans-friendly" experience of care) or negatively (by offering a pathologizing experience of care), and may effect one's gender transition trajectory and self-definition as transmasculine. Please see below for a visual representation of this model:

Table 4

Components of Transmasculine Health Care Provision

Identity Affirming Experiences		Identity Pathologizing Experiences
access to resources	←pathway to care→	avoidance of care/no resources
informed consent	←model of care→	gatekeeping
trans-friendly policies	←organizational qualities→	absence of trans-friendly policies
includes/covers trans health	←insurance status→	denial/exclusion of care
open communication/acceptance	←provider communication→	hostility/misdiagnosis/non-disclosure

Chapter 5: Discussion

This study investigated the identity development process and the healthcare experiences of 28 transmasculine identified individuals. The main purpose of this chapter is to summarize, discuss, and elaborate upon the findings in the context of the literature. First, the chapter will address factors contributing to transmasculine identity development at the cultural, institutional, organizational, and personal levels of analysis. Next, the importance of communication between transmasculine patients and health providers will be discussed. Finally, this chapter will conclude with a discussion of implications for social work practice, areas for future research, and the limitations of the study.

As previously discussed in the literature review, much of the existing research on transgenderism has used the DSM model of Gender Identity Disorder (GID) to classify non-normative gender identities and expressions. This model roots the transgender experience in a narrative of internal distress over gender and severe body dysphoria. The results of this study indicate that transmasculine identity development is inadequately classified using the DSM model of GID. Transmasculine individuals do not all experience body dysphoria, and instead often feel that their female bodies do not adequately represent or portray to the world how they feel inside. Therefore, the decision to transition is less tied into the embodied experience of gender (although this does play a role), but is largely driven by the desire to change the body to reflect the inner sense of self. Instead of viewing transmasculine identity as an individual, disordered experience of identity, it is important to incorporate the personal, social, and cultural factors that influence transmasculine identity development. Exploring the relationship between and among these various influences allows for a more complete understanding of transmasculine identity development and a conceptualization of transmasculinity outside of the lens of medical pathologization.

Identity development is a comprehensive process whereby a person comes to terms in understanding and claiming his or her identity as a sexual minority person (Morrow & Messenger, 2006). Many of the existing models of transgender identity development, generally, and transmasculine identity development, specifically, are limited because they do not address post-transition identity development. The results of this study suggest that many transmasculine individuals continue to change and develop their gender identities even after they have undergone physical transition to reflect a male body or appearance.

The medical model of GID uses a disease-based model (Bockting, 2009), which assumes that a narrative of distress can be alleviated through establishing congruence between sex, gender, and gender role. The goal of this model is to "treat" the condition, whether through therapy or medical transition services. The result of this "treatment" is erasure of transgender identity, because under this model, by establishing congruence between body and identity, transmasculine individuals should blend into cisgender, heterosexual male community. However, transmasculine individuals do not always desire to "be male" or do not espouse a binary male identity. Instead, they use various other terms (such as transman, transguy, transmale, etc.) to describe their identities, indicating that "male" and "female" are limiting options to choose from when describing the specificity of the transmasculine experience. Often, after changing their bodies to reflect to the world that they are "not female", members of the

transmasculine community subsequently discover that they are "not male" either, and take steps to *de-transition* to a neutral gender category. This does not reflect a failed treatment outcome or sense of regret regarding undergoing medical transition; instead, it reflects the capacity for on-going identity development outside of the medical realm. Finally, it is important for many transmasculine individuals to not blend in with cisgender/heterosexual men. The desired outcome of undergoing transition is not necessarily to "become male", but is a more intentional process of building a self that can be visibly queer and acknowledged as such by others in the transgender and queer communities.

In order to more completely understand the process of transmasculine identity development, there is a need for a shift in our classification and understanding of transmasculinity. One suggestion is to replace the distress model with an identity based model (Bockting, 2009), in which gender variance is an example of human diversity, and those with transgender identities are acknowledged as experiencing gender and sexuality differently than non-transgender men and women. Using the study of narrative identity, sociologist Donileen Loseke (2007) argues that narratives create identity at all levels of human social life, including cultural, institutional, organizational, and personal levels. This paradigm offers a useful structure to explore transmasculine identity development outside of the narrative of distress, and to help move toward an identity based model. Shifting the focus from viewing transmasculinity solely as an individual problem or disorder, and incorporating social and cultural influences, may move us closer to the goal of replacing the distress model with the identity based model of transmasculinity. In the section that follows, I will explore the cultural, institutional, organizational, and personal influences on transgender identity development.

Cultural influences

Cultural identities "construct symbolic boundaries around types of social actors" (Lamont & Virag, 2002, as cited in Loseke, 2007, p. 661). With regard to gender, mainstream cultural assumptions that there are only two categories (male and female) suggest that one's physical body predicts what their gender identity and expression will and should be. From this view, one with female body characteristics should reflect a female gender identity. For this reason, transgender and non-binary identified individuals are largely invisible in this culture. As a result, transmasculine individuals struggle with "feeling male" in a female body, and it is not until other options (learning about gender transition, meeting another transgender person who reflects a positive image of transmasculinity) emerge that individuals can move forward with identity development. The emergence of these options often occurs at the cultural level, through the influence of media (movies) or through social networking sites like youtube.com or Facebook. These venues introduce and expose people to the option to transition socially and/or medically, shape how transmasculine people self-define, and impact how they move forward with accessing medical services related to transition.

The culturally rooted notion that gender is binary influences transmasculine identity development directly, by forcing those in early stages of transition to feel that they need to choose between the two gender categories. Prior to learning about various ways to express transmasculinity, the sense is that one is "not female" so as a default must be male, and this notion defines much of the early process of transmasculine gender development. Likewise, non-

transgender people (therapists and medical professionals included) also assume that there are only two gender options, and may inadvertently counsel transgender clients into a binary gender category, or only grant access to services based on their personal assumptions and understanding of what it means to be "male" or "female". If transmasculine individuals seeking gender services reflect a stereotypically masculine appearance and state a desire to "be male" and "live as male", they are less likely to encounter barriers to accessing services than those with non-conventional appearance or those who state a desire to transition to be "not female, but not male either".

Cultural narratives about gender and transmasculinity are relevant because of the western cultural commitment to dualisms, including mind/body, real/unreal, and male/female (Scheper-Hughes & Lock, 1987). Certain concepts and assumptions about bodies and biological reductionism have been privileged in western thinking. These assumptions about gender being binary and equating male body with male identity and female body with female identity impact transmasculine individuals because it is assumed that when this is not the case, it creates a social problem in need of repair. To address such a "crisis" in culture, institutional narratives are needed to legitimize the need to fix the problem by defining it as an individual/personal and medicalized narrative of distress. In order to regulate and control bodies and identities in terms of gender and sexuality, institutional policies are used as an agent of social and political control.

Institutional influences

Narratives of institutional identity shape policies, which define a social problem, identify the cause of the problem, and define the policy's target population (Loseke, 2007). Institutional influences serve as a justification for creating policy to categorize people into two groups: those who are deserving of help, and those who are not (Loseke, 2007). Institutional narratives shape transmasculine identity development and expression in a number of important ways. First, the presence of Gender Identity Disorder in the DSM is used to delineate/define those who "meet criteria" for the diagnosis and those who do not by one's level of distress or pathology over disordered identity. This is important because the diagnosis of GID and whether one meets criteria often dictates their eligibility and readiness to receive medical services related to transition. Transmasculine individuals are often forced to produce a "distress narrative" in order to meet criteria for medical services. Those without the distress component to their identities may be deemed as inappropriate to receive medical services by providers who are using the DSM model of Gender Identity Disorder.

The use of the DSM diagnosis has been institutionalized into the current Standards of Care for transgender health. The World Professional Association for Transgender Health (WPATH) Standards of Care themselves serve to categorize transmasculine individuals into one of two groups: those who are "ready and eligible" for services and those who are not. According to these guidelines, it is at the discretion of the mental health and medical providers to determine this readiness and eligibility based on their assumptions about gender, masculinity, and femininity. The locus of power lies with practitioners who must rely on institutionalized standards of criteria that do not always apply to the lived experiences of transmasculine patients.

For example, based on the interview data, transmasculine identity was rarely conceptualized or experienced by participants in terms of having a "medical problem".

However, the institutionalized language of "diagnosis" and "treatment" for a disorder indicates that transmasculinity/transgenderism is impacted by the process of medicalization. Medicalization is "the process by which non-medical problems become defined and treated…in terms of illness and disorders (Conrad, 2007). Institutionalized practices (such as teaching the "distress model" in medical and social work schools) tend to rely on the DSM, which requires transmasculine individuals to express distress prior to granting them access to medical services, and health insurance policies which deny care based on transgender status all reinforce the binary notions of gender and diminish the subjectivity of those with different experiences and expressions of gender.

At an institutional level, the "distress narrative" of transgender identity is often necessary to justify the need for health services. Once transgender identity is "diagnosed" and defined by the medical or mental health practitioner as a legitimate problem in need of repair, then it becomes valid and morally sound to seek health services related to transition. Outside of the medical realm, it is difficult for transmasculine individuals to justify why they would choose to transition if their narrative was not one of distress and pathology. This leads to the issue of how the distress narrative can be replaced with a diversity/strength narrative of transmasculinity, while continuing to justify the need for medical transition related services. One solution to this issue can be found by turning to the organizational level of identity, where services are provided, policies are implemented, and medicalization is resisted.

Organizational influences

The main difference between institutional and organizational narratives of identity is that organizational narratives do not necessarily stem directly from social policy (Loseke, 2007). That is, while the governing organizations such as the APA and World Professional Association for Transgender Health (WPATH) may play a direct role in creating the policies that guide treatment decisions, organizational influences occur at the direct level of service provision. Organizational narratives of transmasculine identity are created and maintained by health organizations and social services programs designed to repair troubled identities (Loseke, 2007). At this level, health organizations (such as Kaiser Permanente) set boundaries on who is eligible for services and who is not. Some organizations, driven by managed care imperatives/policies, use strict definitions and boundaries to determine who is and is not eligible for services; others may use a more flexible framework to determine client eligibility. Organizational approaches to transgender health care can be paramount to the process of affirming transmasculine identity development. In some health organizations that rely on the DSM/distress model for health care provision, transmasculine patients may present with a certain narrative to avoid denial of services. Conversely, in health organizations that approach transgender care from an "informed consent" perspective, (where providers assist patients with making informed decisions about their own health care, as opposed to having the provider make the decision based on whether or not the patient meets criteria for GID), transmasculine patients can use a narrative rooted in strength and non-pathologized sense of self as transgender and still receive access to health services.

There are several additional ways that organizational factors contribute to a trans-affirming experience of identity. Transmasculine patients who are able to use the name and

pronouns of their choice (regardless of "legal" name or medical transition status) report a more positive experience in receiving health services. Agency forms that allow transmasculine patients to indicate both gender identity and assigned sex at birth are also useful in creating an organizational environment that is trans-affirming. The mere presence of these options on health intake forms indicate to transgender patients that the providers likely have at least minimal training about or knowledge of trans health concerns, bodies, and identities. Other affirming organizational qualities included non-pathologizing assessment questions, prescriptions and medical records reflecting the patient's chosen name/gender, availability of gender neutral bathroom facilities, reception staff sensitivity about transgender issues, and decreased waiting room time. Receiving health services in organizations with these trans-affirming qualities contribute to a positive experience in health care, while subsequently making room for multiple subjectivities outside of a narrative of pathology or distress.

Personal influences

In addition to cultural, institutional, and organizational factors, the personal level of narrative identity impacts one's process or experience of transmasculine identity development. Factors such as personality, resilience, personal preferences, ethnicity, education level, and socioeconomic status all impact how an individual defines themselves with regard to their gender and how they choose to undergo transition. It is important to note that personal narratives of identity may change based on the setting or situation. Because of cultural/institutional/organizational levels of identity discussed above, individuals must often perpetuate a personal narrative rooted in distress and body dysphoria, particularly in medical settings, in order to gain access to services. For some transmasculine individuals, a more authentic experience of identity is that one can still desire to change in the absence of self-hatred, and can still celebrate the self but simultaneously require access to services. This "mismatch" between one's true self and the personal narrative that is often portrayed to others may exist in part because "social actors know what type of story they must tell to achieve their goals" (Loseke, 2007, p. 672), which is often the case with transmasculine individuals who are seeking health services. However, transmasculine individuals may also refuse to embrace new stories (i.e., the distress narratives) about themselves, which is evidenced by how they often enter into the health care system as informed consumers.

Personal narratives of transmasculine identity development, diverse as they may be, cannot be understood as apart from history and culture (Loseke, 2007). Also, personal narratives of transmasculine identity development are impacted by social interactions with others, including significant others, family members, friends, coworkers, and even strangers. Transmasculine individuals often delay medical transition based on relationships with significant others and children. Similarly, interaction with strangers (or, the perception of others) is a frequently cited impetus for pursuing physical transition. This need to make one's true self known to others speaks to the importance of social interactions in the process of transmasculine identity development and expression.

Provider-patient Communication

The personal, social, organizational, institutional, and cultural levels of identity narrative

all offer separate and overlapping units of analysis for transmasculine identity development. It is important to acknowledge how different factors contribute to and influence this process, specifically in the realm of health care provision. Just as social interactions are important to the process of identity development, communication with health providers (including primary care physicians, OBGYNs, endocrinologists, surgeons, and mental health providers) and "Coming out" as transmasculine to providers are central to identity development.

There is a small body of literature focusing on "coming out" as LGBT to health care providers (Brotman, Ryan, Jalbert, & Rowe, 2002; Cant, 2006; Corrigan & Matthews, 2003; Taylor, 1999); however, these studies focus on lesbians and gay men, and do not include transgender patients in their samples. Overall, it is thought to be beneficial to sexual minority identity development to disclose identity to others, which fosters personal growth and empowerment, and increases communication, self-confidence, and self-image (Berzon, 2001). Transmasculine individuals experience these positive benefits when they are able to come out to providers and receive a positive/affirming response. Not only do many transmasculine individuals feel that coming out is key to receiving adequate health care, but being seen, acknowledged, and accepted by a provider after coming out increases self-esteem and normalizes and de-pathologizes the experience of transmasculinity. Conversely, individuals may avoid coming out for fear of rejection, perceived hostility, discrimination, and stress (Morrow and Messenger, 2006). Transmasculine individuals who choose not to disclose their identity status to providers (either by presenting as female and not disclosing transgender identity, or by presenting as male and not disclosing transgender status) may do so as a result of past negative experiences with health providers during which they experienced overt hostility or discrimination. Also, transmasculine individuals avoid disclosure as a strategy to avoid stress and rejection.

It is important to highlight that transgender patients, especially those at early stages of transition, do not always have a choice about whether or not to come out as transgender to medical and mental health providers. Often, simply showing up as male to a gynecology exam, or producing an insurance card that shows a mismatch between gender presentation and "legal" gender is enough to "out" someone as transgender in a healthcare setting. Unlike lesbian, gay, and bisexual patients, who can often make a conscious decision to withhold disclosure if they do not have a trusting relationship with their health provider, transmasculine individuals must rely on medical professionals for access to transition related care, which inherently involves the need to come out to a provider. Disclosure of transmasculine identity status, whether voluntary or forced, is important in defining a patient's experience of health care. The provider's response to the disclosure is equally as important in defining whether the interaction is affirming or pathologizing to one's identity (Eliason & Hughes, 2004). Those providers who acknowledged the limits of their knowledge, listened to the patient, and researched appropriate treatment options were able to provide a more affirming and normalizing experience to the transgender patient. Conversely, patients of providers who responded with hostility or who labeled the patient as mentally ill were more likely to subsequently avoid care because they felt stigmatized and pathologized by the provider.

Because providers are often not knowledgeable about transgenderism, it is imperative that physicians and transmasculine patients learn how improve communication with one another.

Doctors and other health providers must be open to learning from their transgender patients just as patients must rely on their providers for medical and mental health treatment and advice. It has been shown that decision making in health settings that is collaborative instead of authoritarian is better in terms of the health outcomes of the patient (Drake, Deegan, & Rapp, 2010; Drotar, Crawford, & Bonner, 2010; Lown, Hanson, & Clark, 2009; Politi & Street, 2011; Westberg & Jason, 1993). In authoritarian models, patients are treated as passive recipients of care, and the physician determines the patient's medical needs and goals of care. In terms of transmasculinity, this often manifests itself with providers telling patients how to transition or whether they are "eligible" for health services based on appearance or gender presentation.

In collaborative models of care, patients and physicians are viewed as partners: the physician is viewed as having unique skills and medical knowledge, while the patient is viewed as having knowledge of their own beliefs, personal value systems, and individual conception of self with regard to transgender identity. Because the transgender experience is so diverse, it would be unrealistic for medical practitioners to understand a patients' individual conceptualization of their own gender identity prior to having a conversation with the patient. In order for a patient to communicate their health needs clearly and honestly, there is a need for trust "based on the expectation that physicians will assist patients to make decisions that patients deem to be in their best interest (Katz, 2002). One challenge to this approach is that both doctors and patients "bring their vulnerabilities to the decision making process…and are authors and victims of their conflicting motivations, interests, and expectations" (Katz, 2002). Transmasculine patients, especially those seeking services for transition, don't have a choice but to bring their vulnerabilities to the exam table. However, they also bring motivations, interests, and expectations, based on past experiences and wider spread community narratives about how transgender people are treated in the health care system. Should more providers become aware of this dynamic, while being willing to admit to the limits of their knowledge and their biases about transgenderism, transgender patients may be able to more adequately have their health care needs met within a treatment dynamic that is based on mutual trust.

The importance of micro level interactions between transmasculine patients and providers and the impact these interactions have on identity development should not be taken lightly. However, this dynamic often remains invisible when viewing the provider/patient relationship through the lens of the biomedical model, which focuses on "treating the disorder" and deemphasizes the importance of the therapeutic relationship. An alternative to the biomedical model is the Relationship-Centered Model of Health Care (Apker, 2012). Relationship-Centered Care is a clinical philosophy that stresses partnership, careful attention to the relational process, shared decision making between patient and provider, and self-awareness (Suchman, 2006). In this model, the emphasis is on the ways that health care provision and healing occurs in the context of a relationship which includes the personhood of both providers and transgender patients, who bring a unique set of values and perspectives to the examination room. Relationship centered care has shown to increase adherence to clinical advice and improvement in functional status, and an increase in patients' involvement in their own care (Beach & Iniu, 2006; Dimatteo et al., 1993). This model shows promise and is compatible with identity-affirming transmasculine health care provision, particularly with regard to the need for a paradigm shift from the gatekeeping model to the informed consent model.

Implications for Social Work

This dissertation has several important implications for the field of social work. The profession of social work has a long history in educating its members on the nature of social diversity and oppression, and can use research as a tool to promote a nonjudgmental attitude toward transgender people and develop services that are trans-friendly (Kenagy & Hsieh, 2005). This current project may impact the standards of care for the treatment of transmasculine individuals by highlighting the diversity of experience and gender transition needs that are specific to the transmasculine community. The aim of this research was to enhance the profession's understanding of a complex population with the hope that the results of this project may impact health and social welfare agency policies and service provision procedures that currently only recognize the binary identities of "male" and "female". This dissertation was developed to not only promote educational resources about the lived experiences of those who identify as transmasculine, but to portray their lives compassionately and from a non-medicalized lens.

Given the barriers to accessing health and mental health services for members of the transmasculine community, and the need for a shift in the model of transgender health care provision, there are several important implications for the profession of social work. The most obvious is that transgender people often seek services in settings which employ social workers. Transpeople may seek services from social workers for gender transition-related care, as many without private funds may rely on mental health clinics to gain access to hormone therapy and surgical interventions. It is important for all social workers employed in public welfare agencies to be aware of current standards of care for gender transition and if a trans client is receiving public sector mental health services through a clinic where there is not a gender specialist available, the social worker should know to explore all avenues of referring the client to a trans-affirming agency or otherwise assisting the client in gaining access to necessary services. There is a significant correlation between transgender client satisfaction and clients perceptions of their therapist's expertise in transgender mental health (Rachlin, 2002). That is, the more knowledgeable and sensitive the social worker is to transgender health concerns, the more able and willing to engage in the therapeutic relationship a client is likely to be, thus resulting in a more effective therapeutic relationship.

Another important implication for social workers is that transmasculine clients may present for assistance at various stages of their transition process, and not solely for issues related to gender. Social workers may be called upon by transmasculine clients for various concerns, including assistance with post-surgical follow-up referrals, family therapy, legal concerns, housing services, and unemployment benefits. Child welfare workers should be aware of general issues pertaining to transgender parenting and/or having a transgender child or adolescent on their caseload. Given the high rates of depression and suicidal ideation in the trans community, social workers in acute and emergency mental health care settings should be knowledgeable about the healthcare needs and psychosocial concerns which are common in the transgender community. Particularly in involuntary settings, social workers and other medical professionals should be affirming of clients' gender identities and comfortable in assessing for and discussing potential gender identity concerns. Transpeople who receive services in these settings typically

have no choice in their assigned social worker or provider, as this person is often assigned based on caseload, insurance status, or catchment area. As a result, it is crucial for *all* social workers to be prepared to work with transgender clients, and have an understanding of the importance of and sensitivity to transgender issues in social work practice.

One significant challenge for gender variant clients receiving services in public health and social welfare settings is that most agencies only recognize the categories of "male" and "female" as valid expressions of gender identity. Practitioners often have no experience or understanding of the diverse spectrum of possible gender identities, including genderqueer, third gender, or other non-binary identities. This is particularly important in traditionally "gendered" services such as acute care mental health, substance abuse treatment, or criminal justice settings in which clients are too often housed based on their genitalia, as opposed to their gender identity. Trans-affirming agency policies should be developed in health care settings regarding proper name/pronoun usage, and using intake forms with trans-affirming language (i.e., 'partner' instead of husband or wife). Even the presence of a non-binary gender option on agency intake forms may help trans people to feel as if their providers are affirming and may give a trans client an opportunity to open the discussion regarding gender-related concerns.

Despite the need for trans-affirming providers in health and social services agencies, current social work programs lack formal, specialized training to work with transgender individuals.   As a result, the National Association of Social Workers (NASW) has begun to acknowledge the need for trans-affirming educational content in the schools of social work. The current version of the policy statement for transgender and gender identity issues states that "discrimination and prejudice directed against any individuals on the basis of gender identity or expression, whether real or perceived, are damaging to the social, emotional, psychological, physical, and economic well-being of affected individuals as well as society as a whole, and the NASW seeks to eliminate discrimination based on gender both inside and outside of the profession, in public and private sectors" (NASW Position Statement, n.d.). The NASW also encourages the implementation of continuing education, anti-discrimination, public awareness, increased access to health and mental health services, and the adoption of laws to preserve the well-being of transgender individuals. The current state of research on transgender health and mental health highlights the urgent need for gender identity content to be routinely integrated into social work education programs at both the Bachelor's and Master's Levels. Just as all social workers should have core competency in areas of race and sexual orientation, gender identity content must be integrated into educational programming and minimal standards for inclusion should be outlined in the CSWE curriculum.

Similarly, there is currently no mandated education or training in the area of transgender health in medical and nursing schools, and with proper training, social workers employed in healthcare and mental health settings as part of an interdisciplinary treatment team may be able to facilitate discussions with other medical professionals regarding gender-related concerns of their transgender clients. If provided with adequate education with regard to the health and social welfare needs of transgender individuals, social workers are in a unique position to assist these clients in navigating through a very challenging healthcare system. Social workers can use a holistic and strengths-based approach to working with transgender clients, not just focusing on treating the "disorder", but exploring the individual strengths and challenges in a way that is

affirming of non-normative gender expressions and identities. Social workers may employ a variety of interventions when working with gender variant clients, above and beyond the psychotherapeutically-oriented interventions that are common in mainstream mental health and therapeutic settings. For example, the case management model may be appropriate when working with transgender individuals, through which social workers can be useful in helping clients address psychosocial concerns, assisting with gaining access to resources and referrals, and providing crisis intervention services. Instead of serving as a "gate-keeper" to services, social workers can be instrumental in coordinating care with other medical providers, obtaining informed consent, and helping a trans client negotiate through a very challenging system. Social workers working with transgender clients can think creatively about ways to assist transgender individuals in gaining access to resources. The ability to gather information and share experiences with other transpeople may be key in the early stages of gender transition and in the process of "coming out" as trans. Not only can social workers be helpful with referrals to individual therapy and community-based support groups, but they can help trans clients locate informal resources such as Internet-based support groups and online communities as well.

Areas for Future Research

There are several areas where further research is needed with regard to transgender health, mental health, and social welfare needs. Future areas of research should include the experiences and needs of transgender children and adolescents (particularly trans youth in the healthcare, mental health, and child welfare systems), transpeople of color, transpeople with non-binary gender identities, gender variant people with non-normative sexual identities, and transgender parents. Also, there is a paucity of research on the treatment of transgender individuals who present with eating disorders and chemical dependency concerns, although this has been a recurrent pattern in the clinical setting. There is also a lack of research on the experiences of transpeople in specific social welfare settings, particularly, acute care mental health and substance abuse treatment, and more research is needed to examine the effectiveness of existing interventions in addressing the needs of members of the transgender community. Finally, this research lends preliminary support for the "Informed Consent" model of transgender health care provision, and more research is needed to explore the benefits and outcomes for patients receiving care under this model.

Limitations

There are a number of limitations evident in the use of qualitative methods and data. Qualitative research, like all research, may be subject to the researcher's biases and open to many modes of interpretation. Throughout the stages of design, implementation, and data analysis, I attempted to remain mindful of my biases so that they did not present a biased view of the data. While I attempted to suspend bias or preconceived notions, my personal perspectives and approach to the topic at hand inevitably impacted the questions that were asked, the way that they were asked, and the interpretation of the answers provided.

Rigor is more difficult to demonstrate in qualitative studies than in quantitative studies for a number of reasons. The nature of the design is such that close interactions between participants and the researcher may have impacted the participant responses. For example, as a non-transgender female, participants may have viewed me as an 'outsider' of the transmasculine

community and may have amended their responses accordingly. Conversely, "social desirability" is a threat to the validity of the results, because some respondents may have answered questions in a manner that would be viewed favorably by the researcher. Finally, the transgender community has a history of mistrust of researchers and medical practitioners due to being pathologized, and many of the participants may have answered questions cautiously for this reason. To address this, prior to the interview, I allowed participants to ask questions about the study, and addressed them openly, including "why" as a non-transgender person I was interested in this area of research.

There are a number of additional limitations specific to this research that must be made explicit. First, the sample size of n=28, while appropriate for the method at hand, could be larger to account for variability in the population. The sample was somewhat homogenous in terms of race/ethnicity, with a majority of the respondents being white. The 30% of respondents who were people of color all mentioned race/ethnicity as part of their understanding of gender, speaking to a complexity or intersectionality of different identities that was undoubtedly underemphasized in this study due to the small number of participants. Additionally, all participants had to identify as transgender and be "out" as trans enough to participate, even despite strict confidentiality practices; therefore, missing from this research was the voices of those who are transgender but are not out under any circumstance. Finally, the use of the Internet was key in recruitment for this study, and those without or with limited access to the Internet (homeless or rural participants) were under sampled in this study, resulting in a potential selection bias.

<div align="center">Conclusion</div>

This study sought to explore the identity development process and health care experiences of 28 transmasculine-identified individuals. One key finding was that the DSM diagnosis of Gender Identity Disorder (or, GID) is inadequate to describe the experience of transmasculine identity development. Instead of viewing transmasculinity as a personal or individual problem in need of repair, it is helpful to consider the cultural, institutional, organizational, and personal factors that influence transmasculine identity development. The results of this research also indicate that components of health care provision do impact transmasculine identity development. Access to trans-friendly care, an informed consent model of health care provision, trans-friendly organizational qualities, health insurance coverage for transgender health needs, and relationship-centered communication with health providers all lend themselves to a positive, affirming experience of identity. Conversely, lack of access/avoidance of health care, standards of care/gatekeeping model, absence of organizational policies, health insurance denials, and provider hostility all contribute to a pathologized sense of identity and avoidance of the health care system. Gender variance is a reflection of diversity that exists in the world, and transgender identities should be celebrated, not further pathologized. By acknowledging this, we support "the political, social, and spiritual rights of people to define their own identities" (Lev, 2004). There is still much to be learned about the experiences of transpeople who receive services in the health and mental health care systems, and future research should be conducted from a trans-affirming perspective that acknowledges multiple experiences of gender identity and expression.

References

American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

Apker, J. (2012). Communication in health organizations. Polity Press: Malden, MA.

Auerbach, C. & Silverstein, L.B. (2003). *Qualitative data: An introduction to coding and analysis.* New York: New York University Press.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84,* 191-215.

Beach, M.C. & Inui, T. (2006). Relationship-centered care: A constructive re-framing. *Journal of General Internal Medicine, 21(1),* 3-8.

Bem, S.L. (1981). Gender schema theory: A cognitive account of sex typing. *Psychological Review, 88*(4), 354-364.

Bem, S.L. (1993). *The lenses of gender: Transforming the debate on sexual inequality.* New Haven, CT: Yale University Press.

Benjamin, H. (1966). *The transsexual phenomenon.* New York: Julian Press.

Berzon, B. (2001). *Positively gay: New approaches to gay and lesbian life.* Berkeley: Celestial Arts.

Bilodeau, B.L., & Renn, K.A. (2005). Analysis of LGBT identity development models and implications for practice. *New Directions for Student Services*, 111, 25-39.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Englewood Cliffs, NJ: Prentice Hall.

Bockting, W.O. (2008). Psychotherapy and the real life experience: From gender dichotomy to gender diversity. *Sexologies, 17*(4), 211-224.

Bockting. W. O. (2009) Are gender identity disorders mental disorders? Recommendations for revision of the World Professional Association for Transgender Health's Standards of Care. *International Journal of Transgenderism, 11*, 53–62.

Bockting, W. O., Brenner, A. and Coleman, E. (In Press) Gay and bisexual identity development among female-to-male transsexuals in North America: Emergence of a transgender sexuality. *Archives of Sexual Behavior*.

Bockting, W.O, Robinson, B.E., & Rosser, B.R.S. (1998). Transgender HIV prevention: A qualitative needs assessment. *AIDS Care, 10*(4), 505-525.

Bornstein, K. (1996). *Gender outlaw: On men, women and the rest of us.* New York: Routledge.

Bolin, A. (1988). *In search of Eve: Transsexual rites of passage.* New York: Bergin & Garvey.

Brotman, S., Ryan, B., Jalbert, Y. & Rowe, B. (2002). The impact of coming out on health and health care access. *Journal of Health and Social Policy, 15*(1), 1-29.

Bryant, T. & Charmaz, K. (2007). *The SAGE handbook of grounded theory.* Thousand Oaks, CA: Sage.

Bussey, K. & Bandura, A. (1999). Social cognitive development of gender development and differentiation. *Psychological Review, 106*(4), 676-713.

Butler, J. (1993). *Bodies that matter: On the discursive limits of "sex".* New York: Routledge.

Califia, P. (1997). Sex *changes: The politics of transgenderism.* San Francisco: Cleis Press.

Cant, B. (2006). Exploring the implications for health professionals of men coming out as gay in healthcare settings. *Health and Social Care in the Community, 14*(1), 9-16.

Cass, V. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality, 4(*3), 219-235

Cauldwell, D. (1949). Psychopathia Transexualis. *Sexology, 16*: 274-80.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* Thousand Oaks, CA: Sage.

Chodorow, N.J. (1991). *Feminism and psychoanalytic theory.* New Haven, CT: Yale University.

Clements-Nolle, K., Marx, R., Guzman, R., & Katz, M. (2001). HIV Prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. *American Journal of Public Health, 91*(6), 915-921.

Cohen-Kettenis, P. T. and Gooren, L. J. (1999) Transsexualism: A review of etiology, diagnosis, and treatment. *Journal of Psychosomatic Research,* 46(4), 315-333.

Colapinto, J. (2000). *As nature made him: The boy who was raised as a girl.* New York: Harper-Collins.

Coleman, E. & Bockting, W. O. (1988) "Heterosexual" prior to sex reassignment, "homosexual" afterwards: A case study of a female-to-male transsexual. *Journal of Psychology and Human Sexuality* 1(2), 69-82.

Conrad, P. (2007). *The medicalization of society: On the transformation of human conditions into treatable disorders.* Johns Hopkins University Press: Baltimore, MD.

Cooley, C.H. (1902). *Human nature and social order.* New York: Charles Scribner's Sons.

Corrigan, P.W. & Matthews, A.K. (2003). Stigma and disclosure: Implications for coming out of the closet. *Journal of Mental Health, 12*(3), 235-248.

Creswell, J.W. (2007). *Qualitative inquiry and research design: Choosing among five approaches.* Thousand Oaks, CA: Sage.

Cromwell, J. (1999). *Transmen & FTMs: Identities, bodies, genders, and sexualities*. Chicago: University of Illinois Press.

D'Augelli, A. R. Tricket, E. J. , Watts, R. J. and Birman, D. (Eds) (1994) Identity development and sexual orientation: Toward a model of lesbian, gay, and bisexual development. In *Human diversity: Perspectives on people in context*, (312-333). San Francisco: Jossey-Bass.

Davis, K. (1997). Embody-ing theory: Beyond modernist and postmodernist readings of the body. In K. Davis (Ed.), *Embodied practices: Feminist perspectives on the body* (1-23). Thousand Oaks, CA: Sage.

De Cuypere, G., Knudson, G., & Bockting, W. (2010). Response of the World Professional Organization for Transgender Health to the proposed DSM 5 Criteria for Gender Incongruence. Retrieved from http://www.asylumlaw.org on April 1, 2010.

Devor, A.H. (2004). Witnessing and mirroring: A fourteen stage model of transsexual identity formation. *Journal of Gay and Lesbian Psychotherapy, 8*(1), 41-67.

Diamond, M. (2006). Biased-interaction theory of psychosexual development: "How does one know if one is male or female"? *Sex Roles, 55,* 589-600.

Diamond, M. & Sigmundson, H.K. (1997). Management of intersexuality: Guidelines for dealing with individuals with ambiguous genitalia. *Archives of Pediatric and Adolescent Medicine, 151,* 1046-1050.

Dimatteo, M.R., Sherbourne, C.D., Hays, R.D. Physicians' characteristics influence patients' adherence to medical treatment: Results from the Medical Outcomes Study. *Journal of Health Psychology, 12,* 93-102.

Drake, R.E., Deegan, P.E, & Rapp. C. (2010). Promise of shared decision making in mental

health. *Journal of Psychiatric Rehabilitation, 34*(1), 7-13.

Drotar, D., Crawford, P., & Bonner, M. (2010). Collaborative decision-making and promoting treatment adherence in pediatric chronic illness. *Patient Intelligence, 2010*(2), 1-7.

Dutton, L., Koenig, K., & Fennie, K. (2008). Gynecologic care of the female-to-male transgender man. *Journal of Midwifery and Women's Health, 53*(4), 331-337.

Eliason, M. & Hughes, T. (2004). Treatment counselors' attitudes about lesbian, gay, bisexual, and transgendered clients: Urban vs. rural settings. *Substance Use and Misuse, 39*(4), 625-644.

Fausto-Sterling, A. (2000). *Sexing the body: Gender politics and the construction of sexuality.* New York: Basic Books.

Finnegan, D., & McNally, E. (2002). *Counseling lesbian, gay, bisexual, and transgender substance abusers: Dual identities.* New York: Haworth Press

Forshee, A. (2008). Transgender men: A demographic snapshot. *Journal of Gay and Lesbian Social Services, 20*(3), 221-236.

Freud, S. (1962). *Three essays on the theory of sexuality.* New York: Basic Books.

FTM Alliance of Los Angeles. (2004). *Results of the 2003 Health Access Survey: The female-to-male transgender community experiences multiple barriers to healthcare in Southern California.* Los Angeles: FTM Alliance of Los Angeles

Gender Identity Research and Education Society. (2008). *Definition and Synopsis of the Etiology of Adult Gender Identity Disorder and Transsexualism.* http://www.gires.org.uk/Web_Page_Assets/Etiology_definition_signed.htm.

Glaser, B. (1978). *Theoretical sensitivity.* Mill Valley, CA: Sociology Press.

Glaser, B. & Strauss, A. (1965). *Awareness of Dying.* Chicago: Aldine.

Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research.* New Brunswick, NJ: Aldine.

GLBT Health Access Project. (2000). *Access to health care for transgendered persons in greater Boston.* JSI Research and Training Institute.

Goiar, Charlotte (2012*). The Original Harry Benjamin Syndrome Site.* Retrieved from www.shb-info.org

Green, R. (1987). *The sissy boy syndrome and the development of homosexuality*. New Haven: Yale University Press.

Green. J. (2004). Becoming a visible man. Nashville: Vanderbilt University Press.

Green, E., & Peterson, E. (2006). *LGBTTSQI Terminology*. Retrieved from http://www.trans-academics.org/lgbttsqiterminology.pdf

Grossman, A.H., & Augelli, A.R. (2007). Transgender youth and life-threatening behaviors. *Suicide and Life-Threatening Behavior, 37(*5), 527-537.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*(1), 59-82.

Halberstam, J. (1998*). Female Masculinity.* Durham, NC: Duke University Press.

Hale, C.J. (2007). Ethical problems with the mental health evaluation standards of care for adult gender variant prospective patients. *Perspectives in Biology and Medicine, 50*(4), 491-505.

Hansbury, G. (2005). The middle men: An introduction to the transmasculine identities. *Studies in Gender and Sexuality*, *6*, 241-264.

Harawa, N.T., & Bingham, T.A. (2009). Exploring HIV prevention utilization among female sex workers and male-to-female transgenders. *AIDS Education and Prevention, 21*(4),

356-371.

Haraway, D. (1991). A cyborg manifesto: Science, technology, and socialist-feminism in the late 20th century. In *Simians, Cyborgs, and Women: The Reinvention of Nature* (149-81). New York: Routledge.

Harper, C. (2007). *Intersex.* New York: Berg.

Heath, H. & Cowley, S. (2004). Developing a grounded theory approach: a comparison of Glaser and Strauss. *International Journal of Nursing Studies, 41,* 141-150.

Hirschfield, M. (1923) Die intersexuelle Konstitution. *Jahrbuch fuer sexuelle Zwischenstufen 23,*
3-27.

Hoenig, J, Kenna, J (1974) The prevalence of transsexualism in England and Wales. *British Journal of Psychiatry*, 124, 181-190.

Horney, L. (1967). *Feminine psychology.* New York: W.W. Norton.

Informed Consent for Access to Trans Health. (n.d.). Retrieved from www.icath.org

Isay, R.A. (1997). Remove Gender Identity Disorder from the DSM. *Psychiatric News*, 32, 13.

Israel, G.E. & Tarver, D. (1997). *Transgender care: Recommended guidelines, practical information, and personal accounts.* Philadelphia: Temple University.

Karkazis, K. (2008). *Fixing sex: Intersex, medical authority, and lived experiences.* Durham: Duke University Press.

Katz, J. (2002). *The silent world of doctor and patient*. Baltimore: Johns Hopkins University Press.

Kenagy, G. P. (2002). HIV among transgendered people. *AIDS Care, 14*(1), 127-134.

Kenagy, G.P. (2005). Transgender health: Findings from two needs assessments in Philadelphia. *Health and Social Work, 30*(1), 19-26.

Kenagy, G.P. & Hsieh, C.M. (2005). The risk less known: Female-to-male transgender persons' vulnerability to HIV infection. *AIDS Care, 17*(2), 195-207.

Kessler, S.J., & McKenna, W. (1978). *Gender: An ethnomethodological approach.* New York: John Wiley & Sons.

Krafft-Ebing, R. (1947). *Psychopathia sexualis: A medico-legal study.* New York: Pioneer Publications.

Kruijver, F., Zhou, J., Pool, C., Hofman, M., Gooren, L., & Swaab, D. (2000). Male to female transsexual individuals have female neuron numbers in the central subdivision of the bed nucleus of the stria terminalis. *Journal of Clinical Endocrinology & Metabolism, 85*(5), 2034-2041.

Lamont, Michèle and Molnar Virag. 2002. "The Study of Boundaries in the Social Sciences." *Annual Review of Sociology, 28,* 167–95.

Landis, J.R. & Koch, G.G. (1977). The measurement of observer agreement for categorical data. *Biometrics*, *33* (1), 159–174.

Lev, A. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. New York: Haworth Press.

Lewins, F. (1995). *Transsexualism in society: A sociology of male-to-female transsexuals.* South Melbourne, Australia: Macmillan.

Lombardi, E. (2001). Enhancing transgender care. *American Journal of Public Health, 91*(6), 869-872.

Loseke, D. (2007). The study of identity as cultural, institutional, organizational, and personal narratives: Theoretical and empirical integrations. *The Sociological Quarterly, 48*(4),

661-688.

Lothstein, L. (1983). *Female-to-male transsexualism: Historical, clinical, and theoretical issues.* Boston: Routledge.

Loue, S. (1999). *Gender, ethnicity, and health research.* New York: Kluwer Academic/Plenum Publishers.

Lown, B.A., Hanson, J.L., & Clark, W.D. (2009). Mutual influence in shared decision-making: A collaborative study of patient and physicians. *Health Expectations, 12*(2), 160-174.

Luker, K. (2008). *Salsa dancing into the social sciences: Research in an age of info-glut.* Cambridge, MA: Harvard University Press.

Mallon, G. P. (1999b) Knowledge for practice with transgendered persons. *Journal of Gay & Lesbian Social Services*, *10(*:3/4), 1-18.

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum: Qualitative Social Research, 11*(3), Art 8. http://nbn-resolving.de/urn:nbn:de:0114-fqs100387.

McPhail, B.A. (2001). Questioning gender and sexuality binaries: What queer theorists, transgendered individuals, and sex researchers can teach social work. *Journal of Gay and Lesbian Social Services, 17*(1), 3-21.

Merton, R.K. (1957). *Social theory and social structure.* Glencoe, IL: Free Press.

Meyer, et. al, (2001). Standards of Care for Gender Identity Disorders, 6th Version. *World Professional Association for Transgender Health*.

Miles, M.B. & Huberman, A.M. (1994). *Qualitative data analysis: An expanded sourcebook.* Thousand Oaks, CA: Sage Publications.

Mischel, W.A. (1966). *A social learning view of sex differences in behavior.* Stanford, CA: Stanford University Press.

Money, J. (1968). *Sex errors of the body: Dilemmas, education, counseling.* Baltimore: Johns Hopkins Press.

Money, J. (1987). Gender identity and gender transposition: Longitudinal outcome study of 24 male hermaphrodites assigned as boys. *Journal of Sex and Marital Therapy, 13*(2), 75-92.

Money, J. & Ehrhardt, A. (1971). *The differentiation and dimorphism of gender identity from conception to maturity.* Baltimore: Johns Hopkins University Press.

Money, J. & Ehrhardt, A. (1972). *Man and woman, boy and girl.* Baltimore: Johns Hopkins Press.

Morrow, D. & Messenger, L. (2006). *Sexual orientation and gender expression in social work practice: Working with gay, lesbian, bisexual, and transgender people.* NY: Columbia University Press.

National Association of Social Workers (NASW). (2009). Position Statement, Transgender and Gender Identity Issues. Retrieved from http://www.socialworkers.org

Nemoto, T., Operario, D., Keatley, J., Han, L., & Soma, T. (2004). HIV risk behaviors among male-to-female transgender persons of color in San Francisco. *American Journal of Public Health, 94*(7), 1193-1199.

Nestle, J., Howell, C., & Wilchins, R. (Eds). (2002). *Genderqueer: Voices from beyond the sexual binary.* New York: Alyson Books.

Neuman, W. & Kreuger, L. (2003). *Social work research methods: Qualitative and quantitative approaches. Boston, MA: Allyn & Boston.*

Newfield, E., Hart, S., Dibble, S., & Kohler, L. (2006). Female-to-male transgender quality of

life. *Quality of Life Research, 15*(9), 1447-1457.

Olyslager, F., & Conway, L. (2007, September). *On the calculation of the prevalence of transexualism.* Symposium conducted at WPATH 20th International Symposium, Chicago, Illinois.

Patton, M.Q. (2002*). Qualitative research and evaluation methods*. Thousand Oaks, CA: Sage.

Person, E.S. & Ovesey, L. (1984). Homosexual cross-dressers. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 12,* 167-186.

Piaget, J. (1928). *The Child's Conception of the World.* London: Routledge and Kegan Paul.

Piaget, J. (1932/1965*). The moral judgment of the child.* London: Free Press.

Politi, M.C., Street, R.L. (2011). Importance of communication in collaborative decision-making: Facilitating shared mind and the management of uncertainty. *Journal of Evaluation in Clinical Practice, 17*(4), 579-584.

Rachlin, K. (2002) Transgender individuals' experiences of psychotherapy. *International Journal of Transgenderism, 6*(1).

Rachlin, K., Green, J., & Lombardi, E. (2008). Utilization of health care among female-to-male transgender individuals in the United States. *Journal of Homosexuality, 54*(3), 243-258.

Rubin, H. (2003) *Self-made men: Identity and embodiment among transsexual men.* Nashville, TN: Vanderbilt University Press.

Sausa, L.A. (2003). The HIV prevention and educational needs of trans youth: A qualitative study. *Proquest Dissertation,* Retrieved from http://repository.upenn.edu/dissertations/AAI3087465

Sausa, L. A., Sevelius, J., Keatley, J., Iñiguez, J. R., & Reyes, M. (2009). *Policy Recommendations for Inclusive Data Collection of Trans People in HIV Prevention, Care & Services.* Center of Excellence for Transgender HIV Prevention: University of California, San Francisco. Available online at: www.transhealth.ucsf.edu

Scheper-Hughes, N. & Lock, M. (1987). The mindful body: A prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly,* (1), 6-41.

Scottish Needs Assessment Programme. (2001) *Transsexualism and gender dysphoria in Scotland*.

Sedgwick, E.K. (1990). *Epistemology of the closet.* Berkeley: University of California Press.

Sevelius, J.M. (2009). "There's no pamphlet for the kind of sex I have": HIV-related risk factors and protective behaviors among transgender men who have sex with nontransgender men. *Journal of the Association of Nurses in AIDS Care, 20*(5), 398-410.

Singer, T.B. (2006). From the medical gaze to sublime mutations: The ethics of (re)viewing non-normative body images. In Susan Stryker & Stephen Whittle (Eds). *The Transgender Studies Reader (*601-620*).* New York: Routledge.

Spade, D. (2006). Compliance is gendered: Struggling for gender self-determination in a hostile economy. In P. Currah, S. Minter, & R. Juang (Eds). *Transgender Rights* (217-242*).* Minneapolis*:* University of Minnesota Press

Stoller, R.J. (1968a). Male childhood transsexualism. *Journal of the American Academy of Child Psychiatry, 7,* 193-209.

Stoller, R.J. (1982). Transvestism in women. *Archives of Sexual Behavior, 1*(1), 17-28.

Strauss, A. L. & Corbin, J. (1998). *Basics of qualitative research: Grounded theory procedures and techniques.* Thousand Oaks, CA: Sage.

Suchman, A., (2006). A new theoretical foundation for relationship-centered care: Complex

responsive processes of relating. *Journal of General Internal Medicine, 21*(1), 40-44.

Taylor, B. (1999). 'Coming out' as a life transition: homosexual identity formation and its implications for health care practice. *Journal of Advanced Nursing, 30*(2), 520-525.

Thomson, S.B. (2011). Sample size and grounded theory. *JOAAG, 5*(1), 45-52.

Torgrimson, B. & Minson, C. (2005). Sex and gender: What is the difference? *Journal of Applied Physiology, 99*(3), 785-787.

Troiden, R.R (1979). Becoming homosexual: A model of gay identity acquisition. *Psychiatry, 42,* 362-373.

Tsoi, W.F. (1988). The prevalence of transsexualism in Singapore. *Acta Psychiatrica Scandinavica, 78*(4), 501-504.

Westberg, J. & Jason, H. (1993). *Collaborative clinical education: The foundation of effective health care.* New York: Springer.

Wilchins, R. A. (1997). *Read my lips: Sexual subversion and the end of gender.* Ithica, NY: Firebrand Books.

Wilson, B.E., & Reiner, W.G. (1998). Management of intersex: A shifting paradigm. In A.D. Dreger (Ed.), *Intersex in the Age of Ethics,* 119-135. Hagerstown, MD: University Publishing Group.

World Professional Association for Transgender Health (WPATH). (2012). Retrieved from http://www.wpath.org/

Xavier, J.M., Bobbin, M., Singer, B., & Budd, E. (2005). A needs assessment of transgendered people of color living in Washington, DC. *International Journal of Transgenderism, 8(*2/3), 31-47.

Zucker, K. J. (1999) Intersexuality and gender identity differentiation. *Annual Review of Sex Research.* **10** , pp. 1-69.

Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: Guilford Press.

Zucker, K.J., & Lawrence, A.A. (2009). Epidemiology of gender identity disorder: Recommendations for the Standards of Care of the World Professional Association of Transgender Health. *International Journal of Transgenderism, 11*(1), 8-18.

Zucker, K. J. and Spitzer, R. L. (2005). Was the gender identity disorder of childhood diagnosis introduced into DSM-III as a backdoor maneuver to replace homosexuality? A historical note. *Journal of Sex & Martial Therapy, 31,* 31-42.

Appendix A

Recruitment Flier

Seeking FTM/Genderqueer Individuals on the Transmasculine spectrum to participate in a Research Interview!

Do you identify as female-to-male (FTM) transgender or somewhere on the transmasculine spectrum?
or
Do you express or identify your gender with a category other than "male" or "female" (i.e. genderqueer, gender fluid, or another non-binary gender category)?

Have you had at least one contact with a medical/mental health professional or social services agency since the age of 18?

Are you willing to share your experiences by participating in an in-person interview?

I am seeking interview participants to gather data about the experiences of individuals who were "announced" as female at birth but who currently identify their gender as something other than female. I am interested in your experiences in receiving health and mental health care and your interactions with healthcare and social work providers. Individuals 18 and older, of any gender identity, race/ethnic background, sexuality, or (dis)ability level are encouraged to respond.

To Participate, or for more information, please contact: Sarah Schulz, MSW, Ph.D. Candidate at University of California, Berkeley at slschulz@berkeley.edu or 510-730-2392.

~Participants will be compensated for their time with a 25$ Trader Joe's gift Card~

Appendix B

Brief Screening Questionnaire

Brief Demographic Questionnaire

My name is Sarah Schulz. I am a doctoral student at the University of
California, Berkeley, in the Department of Social Welfare. Thank you
for your interest in participating in this research study. The purpose of
this study is to explore your experiences of receiving care in the health,
mental health, or social welfare systems.

If you are willing to participate, I will conduct an interview with you at a
time and location of your choice. The interview will involve questions
about your gender identity and your experiences in the health, mental
health, and social welfare systems. You will also be asked questions
related to your interactions with social workers and other health care
providers. Also, you may be asked questions related to substance abuse
treatment and experiences in the criminal justice system, if applicable.
The interview should last approximately 1.5 hours, and will be audio-
taped with your permission.

Participation in the study is completely voluntary. Please note that
responding to this brief demographic questionnaire does not obligate you
to participate in the study. Rather, it helps determine if you might be a
good candidate to participate. If it is determined that you are *not* eligible
for participation in the study, your information will be immediately
deleted/destroyed. All responses will be handled confidentially. To thank
you for participating, you will receive a 25$ Trader Joe's gift certificate.

Please fill out the following brief demographic questionnaire and e-mail it to slschulz@berkeley.edu. If you do not have access to email or would prefer to speak directly, please call (510) 730-2392 to discuss this information. Once I receive your response, I will contact you to set an interview. Thank you!~

Name: Age:

Ethnicity/Race:

Current Gender Identity:

Assigned/Birth sex:

Have you been seen by a health care or social services provider in any of these settings since the age of 18:

healthcare (hospital, clinic, PCP)   yes   no
mental health (hospital, therapist, psychiatrist)   yes   no
social welfare agency (welfare, homeless shelter)   yes   no

other   please specify _____

What are the days that you are available to participate in an interview (please circle)

Monday   Tuesday   Wednesday   Thursday Friday   Saturday   Sunday

Preferred mode of contact   email _____
                                              Phone_____

Appendix C

Informed Consent Form

UNIVERSITY OF CALIFORNIA AT BERKELEY

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO   SAN FRANCISCO • SANTA BARBARA • SANTA CRUZ

Consent to Participate in Research
Experiences of transmasculine/genderqueer individuals in the health, mental health, and social welfare systems

Introduction and Purpose

My name is Sarah Schulz. I am a doctoral student at the University of California, Berkeley, working with my faculty advisor, Professor Eileen Gambrill, in the School/Department of Social Welfare. I would like to invite you to take part in my research study, which concerns your experiences of receiving care in the health, mental health, and social welfare systems.

Procedures
If you agree to participate in my research, I will conduct an interview with you at a time and location of your choice. The interview will involve questions about your gender identity and your experiences in the health, mental health, and social welfare systems. You will also be asked questions related to your interactions with social workers and other health care providers. Also, you may be asked questions related to substance abuse treatment and experiences in the criminal justice system, if applicable. The interview should last approximately 1 hour. With your permission, I will audiotape and take notes during the interview. The taping is to accurately record the information you provide, and will be used for transcription purposes only. If you choose not to be audiotaped, I will take notes instead. If you agree to being audiotaped but feel uncomfortable at any time during the interview, I can turn off the tape recorder at your request. Or if you don't wish to continue, you can stop the interview at any time.

I expect to conduct only one interview; however, follow-up may be needed for added clarification. If so, I will contact you by e-mail or phone to request this. There would be a maximum of one follow-up interview, which would occur only for the purpose of clarifying the answers to the questions provided during the main interview. The follow-up interview may be conducted via e-mail or telephone and should take no longer than 30 minutes of your time.

Benefits

There is no direct benefit to you from taking part in this study. It is hoped that the research will highlight the unique needs of genderqueer and transmasculine-identified individuals and may impact the standards of care for providing health, mental health, and social welfare services to members of the transgender community.

Risks/Discomforts

You will be asked questions about your past experiences in receiving health and mental health care, with a particular focus on specific interactions that you have had with healthcare and social services providers. You may also be asked to answer questions regarding substance abuse treatment or experiences in the criminal justice system. Depending upon your history, some of the research questions may make you uncomfortable or upset. You are free to decline to answer any questions you don't wish to, or to stop the interview at any time. As with all research, there is a chance that confidentiality could be compromised; however, we are taking precautions to minimize this risk. (*See below for more detail.*)

Confidentiality
Your study data will be handled as confidentially as possible. If results of this study are published or presented, individual names and other personally identifiable information will not be used..

To minimize the risks to confidentiality, we will secure all study-related materials in a locked drawer, on a password protected drive, and no individual identifying information will be connected with your audio-tape transcription. Only the lead researchers and faculty advisors will have access to your audio-recording and transcript.

When the research is completed, the interview transcriptions will be deleted. I will erase the audio tapes directly after the interview is transcribed.

Compensation

To thank you for participating in this study, you will receive a $25 gift card for Trader Joe's after you complete the interview.

Rights
Participation in research is completely voluntary. You are free to decline to take part in the project. You can decline to answer any questions and are free to stop taking part in the project at any time. Whether or not you choose to participate in the research and whether or not you choose to answer a question or continue participating in the project, there will be no penalty to you or loss of benefits to which you are otherwise entitled.

Questions
If you have any questions about this research, please feel free to contact me. I can be reached at *510-730-2392* or *slschulz@berkeley.edu*.

If you have any questions about your rights or treatment as a research participant in this

study, please contact the University of California at Berkeley's Committee for Protection of Human Subjects at 510-642-7461, or e-mail subjects@berkeley.edu.

****

- **CONSENT**

You will be given a copy of this consent form to keep for your own records.

If you wish to participate in this study, please sign and date below.

_____
Participant's Name *(please print)*

_____   _____
Participant's Signature   Date

Appendix D

Demographic Questionnaire

<u>Trans-masculine Study Demographic Questionnaire</u>

Name_____   Age_____

Ethnicity/Race_____

Current Gender Identity_____

Current "Legal" Sex   _____

Current Sexual Orientation_____

Relationship status_____

Number of children (and ages)_____

Occupation_____

Highest level of education completed_____

Approximate Yearly income_____

Medical Insurance Status
(please check all that apply):   [ ] private health insurance through employment/school
                                            [ ] Medicaid
                                            [ ] Medicare
                                            [ ] private insurance through partner/parent
                                            [ ] no medical coverage
                                            [ ] other _____

<u>Medical Transition Status</u>

 Please check all that apply

Current hormone therapy (testosterone) [   ] yes [   ] no   [   ] plan to start in future
          If yes, year started _____

Top/Chest surgery completed?   [   ] yes [   ] no   [   ] plan to complete in future
          If yes, year completed_____

Other transition-related interventions completed? [   ] yes   [   ] no   [   ] plan to complete
          Please specify _____

Appendix E

Semi-structured interview Schedule

Semi-structured interview Schedule

Part 1: gender identity

- How would you describe your current gender identity?

- What has been your path to defining yourself in this way?

- What is the best part of your identity?

- Main challenges your identity has brought to you?

Part 2: Experiences in receiving services

1. Tell me about your experiences receiving services related to your gender transition?

2. Tell me about your experiences in receiving services not related to transition (i.e., gynecology, other health concerns)?

3. What have been your experiences with insurance companies?

Part 3: Interactions with providers

1. How have your interactions with healthcare providers (as mentioned above) impacted the way that you think about yourself, your body, self-image, etc.?

2. Describe the importance of making your identity known to healthcare providers? Have you ever had to "come out" to a provider as trans?

3. What are the qualities that you look for in a healthcare provider?

Appendix F

Final Codebook

Identity Codes:

Code Name	Description of Code
Bottom	Participant discussed decision to pursue bottom surgery (or not)
ChangeID	Transitioning to male gender category prompted change in sexual identity/romantic partner
Coming Out GQ	Participant "came out" as genderqueer prior to medical transition
Culture	Cultural components of gender shaping participants' gender expression
Decision	Factors related to decision to medically transition (or not)
DelayTrans	Participant chose to delay medical transition for specific time period or reason
Discover-media	Participant discovered option to be trans through media (Movies, Books, etc)
Discover-meet	Participant discovered option to be trans through meeting another trans person
Discover-online	Participant discovered option to be trans through use of online communities
Family	Experienced family discord due to gender identity
FearDisclose	Fear of disclosure of transgender status to others
FearTrans	Fear of transition (side effects, that it is the wrong decision)
Feel Male	Participant "Feels Male" or "Feels Not Female" early in life
Female	Participant tried to "be female" prior to coming out as transgender
Financial	Financial barriers to accessing medical transition
Freedom	Reason for transition involved a sense of freedom
LGBT	Participant discussed impact of LGBT community on gender identity development
Mismatch	Participant experiences "mismatch" between gender identity and outward expression
MultipleTrans	Participant took multiple steps to transition at different times
NeedMatch	Participant has a need to change outside body to match the inside
Non-Binary	Experienced challenges as a result of not being categorized as either male or female
NoTrans	Participant chose not to medically transition
Others	Importance of others recognizing participant as male
Outcome	Participant discussed final decision to medically transition (or not)
Positive	Positive representations of transgenderism impacted decision to transition
Post Trans	Participant discussed identity development following medical, legal, or social transition
PreTransChallenge	Participant experienced individual/social challenges prior to medical transition
PrimaryTrans	Participant considers "transgender" to be their primary identity (or not)
Privilege	Privilege of passing as male
Race	Race/ethnicity impacts gender identity and expression
Region	Regional aspects of queerness/LGBT community impact gender expression
Romantic	Experienced difficulty in romantic relationship due to gender identity
Sexual	Sexual identity/practices change post medical transition
Substances	Used drugs and/or alcohol to cope
Suicide	Depression or suicidality
TransPositive	Making the decision to transition had a positive impact on identity
Visibility	Being "out" or "visible" as trans is more important than "blending in" as male

Health Care Codes

Category	Code	
Seeking		**Codes related to Seeking care**
	Avoid	Avoiding health care services as a result of past experience
	Educate-Internet	Sought education on the internet/online communities
	Educate-Support	Sought education through in-person support groups
	Education	Participant educated self informally or formally prior to seeking health care
	LesbianFriendly	Providers were "lesbian friendly" but not "queer" or "trans" friendly
	LGBTCommunity	Participant relied on LGBT community and/or providers when seeking health care
	QueerProvider	The sexual identity or LGBT status of health provider was important
	SelfManage	Participant managed own health needs (did not seek formal care)
Gatekeeping		**receiving care under "standards of care" or gatekeeping model**
	Binary	Provider enforced binary ideas about gender
	Cost-Therapy	The high cost of therapy was a barrier to receiving care
	Gate-MH	Mental health gatekeeping was an aspect of seeking/receiving care
	IC	Participant received care under the informed consent model
	Letter	Participant had to obtain a letter from MH professional to access care
	Proving	Participant had to "prove" male identity to provider
Transgender Policies		**Organizations or individual providers policies for transgender care**
	Bathrooms	availability of gender neutral bathrooms
	binaryMR	medical records reflecting Male/Female as binary and mutually exclusive
	confidentiality	confidentiality concerns related to information sharing
	Honoring	providers and organizations honor/respect transgender identity
	Intake	health intake process
	mismatch	challenges related to gender identity not matching ID or medical record
	questions	assessment questions pertaining to gender/sexuality
	re-gendered	participant was referred to as "female" (despite male appearance)
	StaffTraining	staff are in need of training with regard to transgender concerns
	TransFriendly	qualities that made an organization or provider "trans-friendly"
Health Insurance		**Codes related to health insurance**
	denial	insurance denial due to transgender status
	employee	challenges with insurance-sponsored health care
	NoUse	choosing not to use insurance
	referral	challenges in insurance company referral process
	transbenefits	benefits that cover transgender care

Provider		Provider qualities
	comingout	coming out to providers
	communication	verbal communication with providers about transgender concerns
	hostility	experiencing provider hostility upon disclosure of trans status
	misdiagnose	misdiagnosis as mentally ill or
	prov-educate	providers educate themselves about trans issues
	qualities	qualities of health care providers that impacted experience of care
Consequences		Consequences or outcomes of interactions with providers
	avoidance	participant discussed avoiding health care system
	fragile	interactions during early transition while identity is not yet "solidified"
	health enhancing	positive interactions with providers
	life-saving	health care interactions saved life
	normalizing	interaction with provider was affirming/normalizing to identity
	self-doubt	interaction with provider caused doubt about transgender identity
	stigmatizing	interaction with provider was stigmatizing to identity
	validating	interaction with provider was validating to identity.