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Compelling Care:
The Institutional and Social Change Making of Transmasculine Health in Los Angeles

A dissertation submitted in partial satisfaction of the
requirements for the degree Doctor of Philosophy
in Social Welfare

by

Sid Peterson Jordan

2022

ABSTRACT OF THE DISSERTATION

Compelling Care:
The Institutional and Community Change Making of Transmasculine Health in Los Angeles

by

Sid Peterson Jordan
Doctor of Philosophy in Social Welfare
University of California, Los Angeles, 2022
Professor Ian Holloway, Chair

The right to health care has been a central catalyst of transgender social movements. The social meanings of "transgender health care" have come under acute pressure in the recent period of increased institutional recognition, research funding, political backlash, and social inequality. This dissertation is comprised of three papers that examine how "transgender health care" is negotiated and mobilized for institutional and social change through an in-depth study that focused on transmasculine health in Los Angeles County, California. The research was conducted alongside a community-based participatory action research initiative led by a grassroots organization working to advance gender, racial, and economic justice.

This multiple-methods dissertation includes two papers that are guided by a constructivist grounded theory analysis and based in interviews with 26 transmasculine participants and a third paper that uses cross-sectional data from a community-designed survey of 300 transmasculine adults. The first paper builds on popular trans critiques of clinical healthcare to theorize *compelling care* as a social process through which decentralized acts of self-defense reflect and marshal collective action for building power in clinical medicine. The second paper situates the relational and community-building processes of transmasculine people as health care work outside clinical medicine, surfacing a distinctly racialized gendered care burden and elucidating community-generated frameworks for health and healing interventions. The third paper builds on community-organized mobilizations for transgender healthcare services as institution-building and healthcare resource redistribution using community survey data to model the strategy as structural health equity intervention with demonstrative health benefits. Taken together, the three papers intervene in the medical and political relegation of "transgender health care" to discreet forms of clinical medicine or specialization, recasting transgender health care as a social change phenomenon that is influencing healthcare institutions and reshaping the terms of health caring.

The dissertation of Sid Peterson Jordan is approved.

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University of California, Los Angeles

2022

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Chapter 1: Introduction

In October 2016, the U.S. National Institutes of Health (NIH) recognized transgender people[1] as a "health disparity population" for research purposes (Pérez-Stable, 2016). The designation followed a recent uptick in scholarly publications focused on "transgender health" and accelerated the surge of attention. Between 2013 and 2017 the annual number of published peer-reviewed papers related to transgender health grew by more than 250% (Sweileh, 2018). Prior to the designation, the modicum of federal research funding that had been dedicated to studies related to transgender health had primarily focused on transgender women and HIV prevention and treatment (Coulter et al., 2014). Yet, by 2015, a strategic planning process within the NIH had begun to set additional directions for research, including a broader and largely undefined interest in funding research on "transgender-specific health needs" (Alexander et al., 2016, p. 8). The prospect of new funding, and the rapidly growing research environment, led to an array of scholarly papers with recommendations about how to address scientific knowledge gaps (e.g., Adams et al., 2017; Feldman et al., 2016; MacCarthy et al, 2015; Reisner et al., 2016). Meanwhile, within the interdisciplinary field of trans studies, a related set of questions was emerging: if more research was needed, who are the experts? What theories and practices are most needed? And what exactly constitutes a transgender-specific health need (e.g., Hanssmann, 2010; Labuski & Keo-Meier, 2015; Singer, 2015; Thompson & King, 2015)?

The stakes of these questions are significant for trans people[2], and for health equity research more broadly. One result of pervasive anti-trans stigma and systemic exclusions (James

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[1] The designation was for "sexual and gender minorities," which is defined by the National Institutes for Health Sexual & Gender Minority Research Office as including, but not limited, to people "who identify as lesbian, gay, bisexual, asexual, transgender, Two-Spirit, queer, and/or intersex."

[2] I use "trans people" here, and throughout, to refer to people who identify with the term or see themselves as socially, politically, legally, and/or medically implicated by the term because of their life histories.

et al., 2016) is that few openly trans-identified people or trans-led organizations are positioned to receive federal research funding to conduct transgender health research. More to the point, broad recognition that anti-trans stigma and institutional exclusions are a fundamental cause of health inequities (Hughto et al., 2015) brings attention to the state's role in producing them. Entrenched state investments in binary gender governance are a vestige and ongoing logic of settler colonialism (Arvin, Tuck, & Morril, 2013) and racialized social control and poverty governance (Spade et al., 2015; Ritchie, 2017; Yarbrough, 2021), in which medical researchers have long been complicit (Gill-Peterson, 2018; Malatino, 2019; Somerville, 1994; Washington, 2006).

Thus, while the allocation of public funding signals institutional recognition of these inequities, state investments in research raise ethical and social justice concerns. Among the many potential issues are the fortification of dominant pathologizing approaches, increased biomedical surveillance, and vulnerabilities for research subject exploitation (Llaveria Casselles, 2021; Thompson & King 2015; Vincent, 2018). Such risks have been illustrated in recent cases–for example, a federally funded study using humiliating protocols in an experimental lab (Cummins, 2021) and the misuse of transgender health research findings by state policymakers working to restrict access to gender-affirming care (Greenspan, 2022). At the same time, speculative investments in a growing transgender healthcare market expose how medical research and corporate interests may converge under the guise of creating more "inclusive" healthcare (Geffen & Howard, 2021).

The origins of this dissertation lay in my involvement in a community organizing initiative in Los Angeles that was started in 2015 and led by members of Gender Justice Los Angeles. One of the longest-running trans-led organizations in Los Angeles, Gender Justice LA is a self-described "grassroots social justice organization led by and for gender non-conforming, two-spirit, Black, Indigenous, trans people of color.” Since 2016, I have been part of a strategy to build the organization’s research capacities and advance a health justice agenda under the banner of Transmasculine Health Justice: Los Angeles (TMHJ:LA). A working principle of TMHJ:LA is to honor and build on the knowledge traditions of trans people and to prioritize community building in all aspects of the work (Perez et al., 2021).. The term “health justice” is used to situate the initiative squarely within Gender Justice LA’s commitments to an intersectional racial, economic, and social justice framework. In developing the initiative, we looked to and were especially inspired by organizing principles developed within the Black feminist-led reproductive justice movement (Ross & Solinger, 2017) and disability justice organizing (e.g., Health Justice Commons, n.d.). This included a view that health inequities for transmasculine people, and particularly Black people, Indigenous Peoples and other people of color (BIPOC), are rooted in state institutions and unabated by a for-profit medical-industrial complex.

The right to health care has been a central catalyst of transgender social movements. As a social welfare scholar, this dissertation research was motivated by my interests in the social imprint and demands of trans social movements, and how trans community organizing has and can produce institutional changes. My research interests and involvement with TMHJ:LA came together at a time in which the field was increasingly coalescing around the Grand Challenges for Social Work, including a structural articulation of health inequities and calls for research that moves beyond individual-level interventions (Rodriguez et al., 2016; Walters et al., 2016). Some of the most compatible frameworks include a social determinants of health framework, in which institutions are considered to play a central role in producing health advantages and disadvantages, and a political economy framework that implicates state governance and corporate interests in maintaining conditions of inequality (Ashcroft, 2010). However, greater attention to root cause conditions has contributed to uneasy gaps between theory and practice. If structural changes are needed at the highest levels of social power, what can those with more limited institutional power do to advance transformative change?

Working within the context of TMHJ:LA, whose mission is to build power among people experiencing multiple forms of marginalization, this dissertation focuses primarily on the lived experiences and organizing strategies of transmasculine people (broadly defined), and especially low-income, BIPOC transmasculine people in Los Angeles County. I focused on elaborate community-based frameworks for health justice by identifying theories of "bottom-up" institutional and social change work already in practice. I placed the concept of "transgender health care" at the center of my analysis to better understand how this term was negotiated and mobilized to build power. Taken together, the three papers ask two primary questions: How is a trans health justice politics reshaping the terms of access to clinical healthcare resources? And how are community organizing practices among transmasculine people taking shape on the terrain of health and wellbeing?

Background of the community project and the focus on transmasculine health

Shortly after incorporating in 2002, Gender Justice LA (then the FTM Alliance) launched a local survey on the health of trans men. The study came on the heels of the 2001 publication of "The Los Angeles Transgender Health Study: A Community Report," an effort funded by the University of California, the State of California, and Los Angeles County in which trans men were entirely absent and described as "very difficult to identify and recruit" (Reback et al., 2001, p. 8). By 2004, the FTM Alliance had self-published the "Results of the 2003 Health Access Survey: The female-to-male transgender community experiences multiple barriers to health-care in Southern California," based on findings from 51 FTM participants (Rachlin et al., 2008). In contrast to the 2001 report, written from the voice of non-trans researchers and focused primarily on the sexual and behavioral health of trans women, the FTM Alliance report was self-organized and named to reflect a political focus on institutional problems. For example, the report highlighted how many participants had been denied health care, did not feel comfortable sharing pertinent information with providers, or did not feel confident in their care provider's knowledge (Rachlin et al., 2008). The report joined a few other community-organized survey efforts in this period across the United States, which together began to frame trans men as a population with distinct health care concerns (Rachlin et al., 2008).

When I joined Gender Justice LA in 2016, organizers had recently decided to launch a new survey focused on transmasculine health (a broader term meant to include trans men and gender non-conforming, two spirit, and other trans people who were assigned female at birth). "Invisibility" and "erasure" were some of the key terms used by a new cohort of organizers who felt there had been few changes since the 2004 report in terms of transmasculine inclusion in local health data collection, and therefore, in allocations of public health resources. Transmasculine people had continued to be excluded from research and services driven by HIV funding, and HIV funding was and remains a major source of support for trans-specific research and health care in Los Angeles County. In fact, some felt that exclusions had become even more explicit. For example, some problematized the recent uptake of the "two-step" measure for ascertaining gender demographics (i.e. asking sex assignment at birth and gender identity) as having the unwitting effect of screening out trans men from research and services focused on HIV or sexual health. In another example, and the direct impetus for the new study, data on the health needs of trans men had been conspicuously absent in a 2013 white paper titled "A Roadmap for Improving the Health of Transgender Individuals in Los Angeles County" (King &

McCurtis, 2013), a document that laid the groundwork for a transgender wellness center planned for Los Angeles' downtown core.

In this same period, the number of transmasculine people in Los Angeles County seeking health care services was rapidly increasing. As one recent study showed, there was a nearly 9-fold increase in the number of transgender and non-binary-identified patients in the Kaiser Permanente Health System in Southern California between 2006 and 2014, with the largest proportional increases among young people ages 18 to 25 and those on the transmasculine spectrum (Zhang et al., 2021). Gender Justice LA had been building a base of transmasculine members since its inception and in 2015 began a collaboration with the City of Los Angeles AIDS Coordinator's Office to conduct research related to transmasculine sexual health to identify gaps in HIV prevention resources specifically. After two initial focus groups, in which participants spoke most consistently about a desire for greater visibility for and community building among transmasculine people, several collaborating groups set out to launch an art-based public health campaign called Transmasculine Heath LA (see also #TMHealthLA). An installation of portrait photography featuring transmasculine people, the vast majority of whom were Black people, Indigenous peoples, and other people of color, was exhibited alongside personal narratives and political messages in Los Angeles's iconic downtown public library. At an opening event in June 2016, local trans organizers took to the mic and spoke of the need for health research led by and for trans people, announcing plans to launch a new survey.

I came to Gender Justice LA and the survey project as a university-based collaborator and through my academic advisor. I did not have a health research agenda at the time; rather, I was a trans person implicated in the study, looking for community, and interested in participatory action research as a tool for trans communities to build power over the terms and conditions of research production. Although I held some initial apprehension about the biopolitics of population-based surveying, I found myself emotionally moved by organizers who saw the potential for mobilizing power through a data collection project—as a means of countering erasure and demanding state resources, but also as a practice of developing knowledge about how to better care for each other.

Since the first community research planning meetings in 2016, the project of creating and analyzing a survey involved dozens of trans people across Los Angeles County in an evolving working group of researchers, community organizers, health care workers, artists, and community educators. Building on GJLA's organizing model, we used a range of strategies to involve members, organizational collaborators, and social networks in a deliberate effort to include as many people as possible. In the first year, we designed a survey tool based on priorities set at open membership meetings, interviews with twelve local health care providers specializing in working with trans people (physicians, nurses, social workers, health navigators), and consultations with health researchers at UCLA. In July 2017, we launched the "Transmasculine Sexual Health and Reproductive Justice Research Survey" [TSHRJ] as a collaboration with the City of Los Angeles AIDS coordinator's office and the UCLA Department of Social Welfare (approved by UCLA's Institutional Review Board in 2017; #17-000134). More than 300 transmasculine people who lived, worked, or received health care services in Los Angeles County would participate in the survey in a six-week period. A testament to participant investment in the survey, more than 90% of participants completed the entire survey which took on average 25 minutes to complete and was uncompensated (save for raffle prizes). Many proceeded to write in additional comments.

In the five years since the survey closed, we have engaged in deep data analysis, educational efforts, event production, social media campaigns, filmmaking, social medical campaigns, and arts organizing. A TMHJ:LA website currently features various research products and highlights the centrality of community building to the initiative. By way of example, the website features a discussion of some of self-conscious links between the organizing values , research practices, and health justice:

> Health care is a human right. This project started with a commitment to the principles of Health Justice. Health inequities experienced by Transmasculine people are a direct result of intersecting forms of oppression. We embrace a holistic approach to health knowledge and health care. We recognize the need for trans people to be able to access existing health care systems now, while working to transform society and how health care is organized and delivered in the future. We raise the alarm about health problems facing Transmasculine people in order to address the underlying conditions that drive health inequities. We conducted research as one of many political tools to resist our erasure in health fields and to advocate for access, autonomy, protection, and dignity in health care. We see this as one piece of a broader social change process that is currently taking place within, without, and against institutions that can cause harm (Transmasculine Health Justice: Los Angeles website, 2021).

Dissertation research

This dissertation draws on data from the TSHRJ survey as well as interviews that I collected as part of my independent research. It is comprised of three papers and employs two distinct research methods: a qualitative approach using Constructivist Grounded Theory (CGT)

(Papers 1 and 2) and a quantitative approach using the multivariate analytical techniques of Structural Equation Modeling (SEM) (Paper 3). The multiple methods approach is based in the philosophical assumptions of what Mertens (2007) describes as a “transformative paradigm” for research in which the method selection follows social justice goals and considerations. Using in-depth qualitative interviews for theory construction, I was able to engage and think deeply with participants about their lived experiences and surface theories based in these narratives. Using survey data collected through a community process, I was able to make use of hypothesis-driven techniques to develop and corroborate a community-generated theory of practice within existing health equity promotion frameworks.

Over my years of work with TMHJ:LA, I became committed to the work/life of a participatory action researcher. It was not a priority of the team to develop academic scholarship, nor did I believe that a dissertation project was the appropriate form in which to publish group analyses; hence, the dissertation is not a participatory action research project. All interviews and analyses were conducted independently. However, the questions I asked, the survey data that I utilized, the trust that participants put into the effort, and my analysis were situated in, continuously informed by, and indebted to this community collaboration.

Overview of the three-paper dissertation

The three-paper format is an alternative to a traditional dissertation. This introduction has provided a broad overview of the research setting, my motivations, and conditions in which the study unfolded. The following chapters are presented as stand-alone papers, each with their own introduction, methods, results, and discussion.

In the first paper (Chapter 2), “Compelling Care,” I focus on how critiques of institutional medicine inform negotiations of access to healthcare resources, drawing on in-depth interviews with transmasculine people about their clinical healthcare experiences. The paper responds to a growing body of health research literature that has documented trans patients' accounts of humiliation, exclusion, and violence in clinical healthcare services and repackaged them through liberal frameworks of diversity and inclusion. Building on studies showing that providers enact stigma and violence against trans patients to maintain their professional authority, I explain how participants worked to gain power over the terms of care. In doing so, the paper aims to recuperate the resistance tradition of sharing health care stories as an antiviolence strategy in trans communities, showing self-defense as enabled by, and contributing to, forms of collective protection.

In the second paper (Chapter 3), "Community Care," which is also based on in-depth interviews, I examine relationships and approaches to community building among transmasculine people and outline a distinctive transmasculine social care practice. The paper responds to research highlighting the social and health benefits of being connected to a "trans community," calling attention instead to the undue burden of care labor placed onto trans people and exploring the social and political interdependencies that enable and constrain relations to a collective identity. Rather than asking if being connected to a community is helpful, I insist instead on focusing on how community building can and does produce health interventions. These practices do more than merely buffer stigma or "fill gaps" in existing healthcare services; they extend meanings of health through collectivized and accountable forms of caring.

In the third paper (Chapter 4), "Specializing Care," I turn to a central policy demand that has emerged from trans health activism: public funding for trans-specific healthcare services. I adapt an existing health equity promotion model to test this community-generated structural health intervention. I use data from the TSHRJ survey (n=300), showing that the health benefits of having a trans-specific healthcare provider are not reducible to accessing gender-affirming healthcare interventions but rather are suggestive of receipt of higher quality care.

Guided by the lives of transmasculine people who participated in this study, set against the backdrop of the health justice agendas of trans-led organizations in California, this dissertation shows how transgender health care is a site of negotiation and mobilizable for social and political power. Taken together, the three papers intervene in the medical and political relegation of “transgender health care” to discreet forms of clinical medicine enacted on individual bodies, recasting transgender health care as a social change phenomenon influencing healthcare institutions and reshaping the terms of health caring. In the conclusion (Chapter 5), I situate the theoretical perspectives advanced in this study within the urgent need to expand definitions of transgender health care during this present period of increased political backlash, retrenchment, and regulation.

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Chapter 2: Compelling care: Trans self-defense and collective protection at the clinic

Abstract

In response to hegemonic gender norms and provider authority in U.S. medical systems, transgender people have fought for equitable access through collective processes. Trading stories about mistreatment has been a tool for solidarity organizing, yet these narrative accounts are increasingly repackaged in health research through neoliberal frameworks of diversity and inclusion. Using a constructivist grounded theory research design, this study draws on interviews with 26 local participants in a community-driven health justice initiative led by and for transmasculine people in Los Angeles. Healthcare stories are analyzed to develop a theory of compelling care in which everyday resistance and self-defense in clinical care facilitate forms of collective protection. Protective skepticism is elaborated as shaping four processes: tactical utilization, confronting erasure, redirecting care, and pursuing accountability. The theory highlights trans critique of clinical power as constitutive of social movements for trans health care with practical implications for the development of health equity efforts.

Introduction

> He says, “how do you know you’ve had a hysterectomy?’ And I said, “Well, I’m trans, and I had a uterus, and they took it out. Therefore, I’ve had a hysterectomy.” He says, “You don’t know what a uterus is!” He tells me, “There are no trans guys, there are only trans women and trans guys don’t exist.” And I proceeded to look at him and look at myself and say, “I must have the most extravagant imagination ever because I’m here, and I’m breathing, and I’m sure I have friends like me!”
>
> *– Clark (he), a Black trans man in his early 40s, Los Angeles, California*

Clark tells me health care stories for well over an hour and we laugh a bit. Some of his stories feel well-worn, perfected over the years that he has been retelling them as a community educator. Others seem raw, coming unmoored in whatever space we can share as two trans men of a similar generation. We are explicit about our differences too, particularly those meted out by anti-Black racism. It is because he is a Black man, Clark reminds me, that an emergency room doctor found it easier to assume that he was high and a drug-seeker than it was to believe that his medical history could have included a hysterectomy. It had happened before, he says: “as a Black man, 9 times out of 10 they don’t want to hear nothing I’ve gotta say… There are already misconceptions that are stuck in their head from the time I walk in the door.” When they learn that he is transgender, he quips, “Now, I’m the experiment.”

The problems that trans people face in U.S. healthcare settings are well documented. Several recently published scholarly literature reviews highlight patterns of pervasive misunderstandings, misgendering, neglect, discrimination, refused care, harassment, and assault across multiple fields of practice (Cicero et al., 2019; Heng et al. 2018; Lerner & Robles, 2017; Kcomt, 2019; Sbragia et al., 2020; Snow et al., 2019). A frequently quoted statistic comes from the 2015 U.S. Trans Survey (USTS), the largest national survey of trans people to date, in which one-third of participants said that they had a negative healthcare experience related to their gender in the past year alone (James et. al. 2016). Thousands of trans people have taken to social media to share their experiences using popular social media threads such as #transhealthfail or #transdocfail to index a critique and thus contributing to a growing archive of the scope and nature of the problems (Rubin, 2015).

What trans health failures often reveal is a clash between a two-gender medical system and the reality of trans lives and embodiments. These accounts, ranging from the socially awkward to the abjectly violent, tend to share a common thread in medical knowledge formation and social and institutional practices that anticipate and impose normative binary gender categorization. Bauer and colleagues (2009) used the now broadly influential term *cisnormativity* to describe the habitual expectations in healthcare settings that all patients are either male or female as assigned at birth—norms that are produced and reinforced through institutional and epistemic erasures. As a theory of power, cisnormativity is understood not as an unwitting oversight of healthcare systems, but a governing logic through which sex and gender non-conformity have been defined as unnatural and pathologically deviant through medicine (Fausto-Sterling, 2000; Terry, 2010). Healthcare inequities for trans people are structured and sanctioned by the ways that binary gender categories are portrayed as self-evident, and against which transness is constructed as impossible, anomalous, and less natural (Namaste, 2000).

A primary characteristic of the power imbalance between clinical providers and patients is the clinician's authority to assess, scrutinize, make sense of, and develop recommendations for patients, often across multiple forms of social hierarchy. In interview-based research with trans patients and their care providers, Poteat and colleagues (2013) observed how even when providers aimed to meet their professional obligations, they tended to enact stigma (e.g., blaming, shaming, othering, discriminating) to preserve their sense of professional authority in the face of uncertainty. Stigma, in their analysis, is thus both a product and tool for upholding imbalanced power relations between healthcare providers and patients (Poteat et al., 2013). Paine (2018) described how against a two-gender clinical schema, providers tried to discern and "sort out" how to fit trans and gender nonconforming patients into existing binary biomedical categories. As with Clark's experience in the emergency room, racism colludes in these dynamics such that Black trans people and other trans people of color may be deemed deceptive, increasing the risks of hostile encounters and refusals of care (Agénor et al. 2022; Kattari et al., 2015). The specific intersection of racialized transphobic bias is institutionalized through broader arrangements of social power between a professional class elite that is disproportionately white (Wilbur et al., 2020) and a trans patient population is disproportionately young, poor, and of color (Badgett et al., 2019; Herman et al., 2022).

I take up stories like Clark's carefully, not merely to repeat evidence of the failures of health care systems to recognize and fairly treat trans people, and especially Black trans people. Rather, what I was drawn to in Clark's story is what these moments might help surface about: 1) how patients act to protect themselves while also accessing healthcare resources; and 2) how these interactions interplay at the level of the collective, or how having "friends like me," influences how trans people have and do negotiate for power in care. The study was conducted as one part of a broader community-driven research and organizing initiative in Los Angeles County that focuses on building power for transmasculine people[3], especially low-income and

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[3] I use the term transmasculine throughout with consistency to the local initiative. It was intended as a tactical category to speak broadly to trans people who were assigned female at birth, and with the recognition that many do not use the term to describe their own gender identity. For the purposes of this study, this included (but was not limited to) people who are two-spirit, trans, trans men, non-binary, masculine of center, men, male, intersex,

Black people, Indigenous peoples, and People of Color (BIPOC),[4] to advance health justice. I start with a brief introduction to how the convention of sharing health care “fails” has been a method of collectivizing critiques of medical violence among trans people and the tendency for these narratives to be used instrumentally in support of liberal calls for reform through increased provider training and policy inclusions. I then turn to the stories with transmasculine participants in Los Angeles through which I explore the role of patients as constitutive actors in social change processes as part of the broader imprint that contemporary trans social movements are enacting in clinical medicine.

#TransHealthFail: On Theorizing Medical Violence for Trans Health Justice

In response to hegemonic gender norms and abuses of authority in U.S. medical systems, trans people have fought for equitable access through collective processes. Trading stories about interactions with healthcare providers who were ill-informed, overly intrusive, subtly hostile, and downright abusive has been one tool for solidarity organizing. In good company, these stories provide guidance and forewarning, invite empathy or care, and even offer comedic relief (Hines, 2007). Autobiographical storytelling has been a primary method of knowledge making among trans people, accounting for how the term “trans” came into its present-day significance in transforming twentieth-century scientific categorizations into a social identity and social movement (Carter et al., 2014; Vidal-Ortiz, 2008). Medicine, and its relationship to maintaining white supremacy, has structured scientific and popular ideas about gender difference and who trans people are, cinching its dominance in representations of trans life and trans history (Gill-

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genderqueer, gender non-conforming, female-to-male (FTM), or ftm (used not as an acronym), and who wanted to participate in a project described as focused on “transmasculine health.”

[4] The term Black people, Indigenous peoples, and people of color (or the acronym BIPOC) is used with consistency to the community initiative as a political category for solidarity organizing among those targeted by colonialism and racism.

Peterson, 2018; Meyerowitz, 2002). So too, has resistance to medicalization driven the political imaginaries of and collective organizing for trans liberation as a politics of racial and class solidarity (e.g., Stone, 1991; Feinberg, 1992). As Malatino (2020) contends, trans solidarity in relation to the medical-industrial complex has been "the crucible through which much of our connectivity has emerged" (p. 8).

Trans people have developed dense and complex networks to exchange health information, transforming practices of "transgender health" from individual medical interventions to concepts of community or population health (Singer, 2015) and health social movements (Pearce, 2018). Sharing stories about mistreatment and other "failures" have provided raw materials for grassroots theorizing about institutional inequities for community safety. For example, the quippy shorthand, "transgender broken arm syndrome" came to describe the phenomenon of providers erroneously attributing every health problem to a patient's trans identity or their use of hormones (Freeman & López, 2018; Knutson et al., 2016). More than a comedic turn of phrase, the concept traveled in trans communities because of its salience and offered an analysis to empower trans people to recognize and raise concerns when their symptoms are being mismanaged.

Sharing healthcare stories is powerful in the sense that it exposes healthcare institutions to scrutiny and rejects governing logics of clinical encounters as a fundamentally private sphere. Extending this feminist take, Davis and colleagues (2021) described results from a recent study in which trans people cooperatively analyzed their own healthcare stories and likened their experiences to an "abusive relationship." They build on the concept to illustrate how trans patients experience a pattern of violence in being routinely dismissed, referred on to others, dehumanized, and made to "feel as though their agency in their care is being denied" (p. 192).

These power dynamics were especially illustrative in the context of accessing gender-affirming healthcare interventions where patients reported that their own knowledge about their care needs were dismissed and structurally subordinated to providers' regulatory control (Davis et al. 2021). Using the interpersonal "abuse" analogy provides a potent indictment of the standards of care—a long-term target of trans activism and advocacy (see Kumar et al., 2022; Schwend, 2020). A framework of "abuse" helpfully extends the analysis of power imbalances Poteat and colleagues (2013) observed as a precondition for enacting stigma. It further bridges trans critiques of health care "fails" with Black feminist insistence on the inextricable links between interpersonal harms and institutional violence (Richie, 2022).

Yet, as the qualitative accounts of trans people's experiences in healthcare settings have been introduced into academic research literature and repackaged for healthcare audiences, stories of humiliation or degrading mistreatment have trended toward what Tuck and Yang (2014) critiqued as "rescue research" or "pain tourism"–that is, research resting on the "faulty logic" that documentation can motivate accountability or produce material or political changes. Researchers commonly conclude that the most needed solutions rest in policy protections or training providers to create inclusive environments for trans people. While nondiscrimination policies have helped to eliminate explicit exclusions, for example in health insurance coverage (Baker et al., 2012), they tend to have limited influence in changing norms of practice (Jordan et al., 2020). It is not only tremendously difficult for trans people to bring and substantiate discrimination claims, but such policy solutions tend to perpetuate the fiction that the primary source of harm for trans people is a discriminating person and that the best remedy is individual damages (Spade, 2015). The common recommendations for provider training tends to produce changes that trade in structural critiques for modest skills development (Dean, 2016). These efforts may mitigate harmful behavior (Korpaisarn & Safer, 2018), but tend to replicate the problems of liberal diversity approaches by standing in for (and distracting from) the transformational changes needed to address root causes (Ahmed, 2012). Training approaches absorb time and resources that have so far yielded only modest improvements, leading some to question the strategic value for trans communities in focusing on reforming provider behavior in institutions that have been a source of violence (Hanssmann, 2012).

The stories of trans people's interactions with health care providers have been analyzed to show how institutional power is enacted by providers. This study asks what these stories might offer in terms of understanding the role of patients in broader social movements for trans health justice. Building on an emerging scholarship that highlights the agency of trans patients in responding to and resisting stigma in healthcare settings (e.g., Agénor et al, 2022; Knutson et al., 2016; Poteat et al, 2013; Roller et al., 2015; Seelman & Poteat, 2020), my primary interests were to develop a grounded theory of how patients work to shift power over the terms of their health care with attention to the interplay of individual and collective action.

Methods

This study uses a constructivist grounded theory (CGT) research design as developed and outlined by Kathy Charmaz (2014). Rooted in symbolic interactionism and influenced by pragmatist philosophies, grounded theory is a way to explore social phenomena through studying social interactions with attention to how meanings are coproduced in an exchange of symbolic acts and their interpretations (Blumer, 1969; Charmaz, 2014). Symbolic interactionism is particularly well-suited to the study of clinical encounters where symbols and language play an essential role (Charmaz, 2014). I engaged participants in a community-based initiative in in-depth interviewing about their healthcare experiences using a contemporaneous processes of data collection and analysis and focused on the development of theoretical explanations and understandings, as described below. CGT assumes that the researcher also a part of the study influencing how data collected and analyzed (Berger & Luckmann, 1966; Charmaz, 2014). A critical version of CGT also considers the social conditions in which the study is produced and the extent to which developing theories are compatible with the pursuit of social justice (Clarke, Friese & Washburn, 2017; Charmaz, 2020). Therefore, I start with a description of how I came to the research and the community initiative that informed the study.

Research context, ethics, and approach to reflexivity

The Transmasculine Health Justice: Los Angeles (TMHJ:LA) initiative launched to respond to health inequities by building power in trans communities and trans-led community organizations to devise and direct health promotion strategies. Transmasculine people experience alarming but largely hidden health inequities, including high rates of exposure to interpersonal violence, and symptoms of psychological distress, including depression, anxiety, and suicidality (James et. al. 2016; Marshall et al., 2016; Millet et al., 2018; Toomey et al., 2018; James et al., 2016). The term "heath justice" was used by organizer to describe an underlying politics of countering health inequities through community organizing and at the intersections of gender, racial, economic injustice (Perez et al., 2021), or what health scholars have described as "fundamental causes" (e.g., Hatzenbuehler, Phelan & Link, 2013; Hughto et al., 2015; Phelan & Link, 2015).

I am a transmasculine white person and working member of TMHJ:LA since 2016. I came to the initiative as a graduate student and with a longer history of involvement in trans, racial, economic, and social justice and community health organizing. I conducted this study independently as part of my dissertation research. Participants came to know about the study through TMHJ:LA. I worked to clearly convey my position as a trans person working in and between the academy and community organizations as part of my process of informed consent.

Given my investments in and accountability toward the community initiative, and following Charmaz's (2014) approach, I engaged in reflexive memo-ing practices throughout the study. Writing memos is a central component to the CGT process, and by reflexivity, I refer to efforts to self-interrogate, surface, and probe how my own personal experiences and my values, experiences, and biases might be influencing data collection and analysis. The goal was not to eliminate my perspectives but to make them more transparent and to better reflect participants' experiences, rather than my own. I aimed to ensure my interpretations were sufficiently grounded and emerging from the data by returning to original transcripts many times and, as my theoretical analysis evolved, I tested my developing theories with some of the later study participants, friends, and collaborators.

In-depth interviews

Eligibility was based on criteria set by the community initiative, including being transmasculine[5], ages 18 and older, and currently living, working, or receiving health care in Los Angeles County. Participants learned about the study through recruitment materials circulated through the community initiative, including emails circulated by core team members, social media posts, and print flyers distributed via a range of venues around Los Angeles County. I met participants for interviews at locations of their choosing around the county, including their workplaces and homes, public libraries and parks, and in private offices at community

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[5] Recruitment materials used a range of terms in order to convey a breadth of meaning (e.g. two-spirit, men of trans experience, masculine of center, trans men, non-binary, intersex, genderqueer, gender non-conforming).

organizations and on my university campus, I conducted the last 8 interviews over video-conference technology (after the start of the COVID-19 pandemic). Every participant was offered a $50 gift card or cash. At the end of each interview, I provided a list of local and national health-related resources, discussed some of the resources available based on topics brought up by participants in the interviews (e.g., clinical providers, sexual violence survivor advocacy, political organizing efforts, arts and cultural organizations), and invited participants to contribute resources, which were also posted online on a website for the community initiative. For the analysis I conduct below, I report pseudonyms (and pronouns) that participants chose for the study, as well as their gender, racial, or ethnic identities, as verbatim to a demographic form they completed at end of the interviews. In some cases, I have generalized and masked certain details to further protect anonymity.

Participants

Participants ranged in age from 20-to 61-years-old. Nineteen participants used gender terms that included the word "man" or "male," including: trans man (11), male (5), FTM (i.e., "female-to-male") (3), man (2), transmale (1), and intersex male (1). Many also used terms reflective of a non-conforming or non-binary gender identity, and 7 exclusively used these terms, including: genderqueer (3), gender non-conforming (3), trans or transgender (2), non-binary or "NB" (2), two-spirit (1), masculine of center (1) and transmascfemme (1). None of the participants said that they used the term "transmasculine" for their own gender identity although most said that they found it acceptable as a general or "umbrella" term (and a few did not but participated anyway). Fifteen participants were people of color, including Black or African-American (4), Black and biracial (1), Black and Asian (1), Chinese (1), Filipino (2), Indigenous and Xicanx (1), Latino-American (1), Mexican-American (2), mixed Asian (1), and South Asian

(1), and eleven were white. Other aspects of participants' identities shared included being gay or queer, asexual, parents or caregivers, first- or second-generation immigrants, living with chronic health conditions, former foster youth, and survivors of domestic and sexual violence. All participants had health insurance, including ten who were publicly insured (e.g., Medi-Cal, Medicare, Veterans Affairs).

Analysis

I audio-recorded and transcribed every interview verbatim and wrote field notes immediately before and after each interview. The grounded theory approach uses contemporaneous data collection and analysis such that data collection continues in relation to emerging analytical frameworks until one reaches a point of theoretical saturation (Corbin & Strauss, 2014). This study began with a set of seven pilot interviews which I first collected and analyzed as part of my graduate coursework. Data analyses included a process of initial line-by-line coding to identify meanings and salient interactions in the narratives, followed by analytic memos to process each interview and explore codes and ideas. Focused codes identified processes in the data that I then compared side-by-side to identify emerging social processes. This fostered preliminary identification of key categories that were further developed through ongoing analysis of data from additional interviews. Through the grounded theory process of theoretical sampling, I altered my initial interview questions to explore areas that emerged through analysis as pertinent to participants and their experiences. The remaining interviews were collected over an 18-month period through a process of elaboration and refinement in which I revised the coding structure to develop increasingly specific categories and properties in the data. I also used the analytic software Dedoose to further organize codes into categories in the final theoretical framework presented below. Where possible, I prioritized "in vivo" codes, verbatim phrases used by participants, to better incorporate their language into the analysis. As my analyses progressed, I engaged participants more directly in discussing some of the developing theoretical concepts and checked their impressions of the developing theory.

“Everyday resistance” as a sensitizing analytic

I was influenced from the outset of the study by the concept of “everyday resistance” as developed by Scott (1985) and elaborated by Johansson and Vinthagen (2019) as “a pattern of acts (practice) done by someone subordinated in a power relation that might (temporarily) undermine or destabilize (some aspect of) dominance” (p. 11). In grounded theory, a sensitizing concept is an interpretative tool or a way of seeing or understanding, that can serve as a starting point for analysis (Charmaz, 2014). The concept of everyday resistance offered an interpretive tool as I examined how participants worked to shift power in explicitly or intentional ways, but also by decoding acts that are implicit, subtle, or “hidden” (as in, concealed from those in power) (Scott, 1985; Johansson & Vinthagen 2019). Therefore, I did not ask participants specifically about their “resistance” strategies or use words like “shift power,” rather, I asked general questions about their approach to health care and follow-up questions that ultimately focused on participants’ actions and agency (e.g., “What did you think when that happened?” “Do you remember what you did next?”). Following Johannsson and Vinthagen’s (2019), I was sensitive to heterogeneity in the data related to how participants’ social positions influenced what they experienced in healthcare services, and their acts or practices of resistance, especially in relation to intersecting forms of social power and privilege. I noted when participants named one or more of their social identities or positions, or a provider’s either explicitly (e.g., “As a Black man,” “he was an upper-middle-class white man, Catholic, married, with three kids”) or implicitly (e.g., "how I was raised") and also social advantages that were discussed explicitly (e.g., "I was raised in an affluent family.") or left unmarked (e.g., whiteness, professional job).

Results

The theory of "Compelling Care" provides an explanation of the ways participants acted to protect themselves in clinical health care settings and how these processes were informed by and contributed to collective forms of protection. The interpretive development of the theory builds on an early interview I had with one of my collaborators on the community project who told me that he joined the effort because he was "interested in figuring out a way of how we can make it feel more comfortable while we go in." In my analysis, I wrote a memo about his use of the "we" pronoun and the verb "make." I asked "What might it mean for *us* to *make* health care better? How are we already compelling changes in health care systems?"

The theoretical framework in Figure 1 depicts five categories observed as part of the broader theoretical phenomenon: protective skepticism, tactical utilization, antagonizing erasure, redirecting care, and pursuing accountability. These processes, which are often submerged or siloed behind the closed doors of the clinic, were observed as a broader phenomenon made possible by, and contributing to, a sense of a collective protection. The theory is illustrated as circular pattern represented with a sense of forward motion. Protective skepticism on the outer ring as both underlying or encircling self-defense practices. The ring follows individual actions that may occur in a singular clinical encounter or over time. While the processes are described sequentially, the empirical data suggested a much more overlapping and iterative set of processes. The central core of collective protection representing how individual acts were support by and weaved back to community processes. The arrow moving up from processes of pursuing accountability illustrates how processes of self-defense and collection protection move through individual acts of protection toward demands for institutional change.

Figure 1: Compelling care: A theory of self-defense and collective protection

Protective skepticism: Anticipating trouble and preparing for a fight

Participants were not naïve or unsuspecting healthcare consumers, rather they approached healthcare interactions knowing that meaningful care was far from guaranteed. Past experiences had left many on edge about whether they would be dismissed or well cared for in the future, but also more critical and strategic in their engagements with providers. Consistent with what has been broadly reported in the research literature about trans people's health care experiences, participants in this study had been refused care, "literally laughed at," unnecessarily tested and examined, given absurd or dead wrong advice, and as one participant put it, gawked at "like the Loch Ness Monster." Based on these experiences, they anticipated trouble and prepared for a fight in clinical interactions. They viscerally assessed their safety using language like “being in a tender spot,” “under a petri-dish,” and “attended to like an object.” Black participants, in particular, used words like “dangerous,” “a crapshoot,” and “a last resort.” Mahlik (he/they), a Black and Asian gender non-conforming person in their late 30s, used the word “hostile” several times in explaining to me:

> You never know what’s going to happen. It’s like this tense feeling all the time like I just want to get out of there! … It feels like a hostile environment. You have to fend for yourself in this situation.

Protective skepticism speaks to a social process of coming to understand one’s marginalized social status in healthcare settings and was a precondition for the other processes described below. Participants anticipated trouble because of their gender, but also because they were (variously) Black, brown, poor, publicly insured, queer, young, a drug user (or perceived to be), a survivor of violence, or someone receiving psychiatric care. Skepticism in health care was also rooted in cultural knowledge from families of origin and political frameworks. A few participants registered broader institutional critiques telling me that the healthcare system is “broken,” “racist and anti-Black,” and “designed” to disadvantage poor people. Following a story about a recent negative encounter, Edgar (he), a Mexican-American male in his late 30s, spoke to the intersections of racial and class disadvantages:

> In my heart, I feel it's due to the fact that [the provider] accepts Medi-Cal and therefore they're dealing with a lot of minority and low-income patients, and community members. I definitely feel like the treatment is different because of that. It’s of less quality.

Seeing these problems as institutional, on a scale broader than a single encounter or an individual provider, explained why some participants were sympathetic to healthcare workers even when they were mistreated by them. Some registered a sense of class solidarity with workers in with lower authority and lower-wage positions (e.g. receptionists, technicians). In another register, those who reported relatively positive experiences with health care providers or told me that they had found a provider that they “loved,” tended to use disclaimers. They had been “lucky,” found “a needle in a haystack,” or, as one person put it, “had the best experience with trans health care probably out of anyone.”

Participants prepared for fight in the clinic. They approached encounters cautiously, imagined a range of scenarios, brought back-up, and planned escapes. They “prepared emotionally,” tried to “stay chill,” learned to have “thick skin,” or to “go in with armor.” Protective skepticism was a tool sharpened through engagements in community organizing efforts related specifically to “trans health care,” in which nearly everyone I interviewed had engaged with in some way (e.g., attending events and conferences, joining support groups and online communities, fighting for protective policies, volunteering and working with trans-led organization). Feeling part of a collective experience as a trans person in healthcare services informed how participants thought about their clinical interactions. For example, Chen (they), a mixed, Asian, nonbinary FTM in their early 20s, told me:

> So many people have fought for inclusion, just this whole history, all these movements, all these people. If I don’t say something, it won’t be easier for the next person.

However, as Chen noted, “saying something” could increase personal risks and so this was felt both as a responsibility and burden. Chen went on to tell me that they preferred not to feel “angry” when in a vulnerable position. At the same time, the belief that saying might alter the course for another trans person in the future was a motivating factor to act. For example, Isaac (they), a two-spirit Indigenous and Latinx person in their 50s, said that they were uncomfortable advocating for themselves in clinical settings, but they were “always thinking about future generations.” Illuminating the individual/collective nature of protective skepticism, feeling a part of a collective fight helped some build a sense of entitlement to feel “angry” (or “fed up” or “tired of the bullshit”) which, in turn, fueled participants acts of compelling care.

Tactical utilization: Assessing providers, selective engagement, and opting out

Participants worked to prevent and minimize exposures to harm by being judicious in seeking care, assessing providers, engaging selectively, and opting out of bad situations. Participants assessed providers by establishing criteria, formulating values, gauging responses, and gathering clues to determine, as one person put it, “is this person going to be cool, or am I going to need to find somebody else?” In one explicit example, Trystan (he), a white intersex male (with lived trans experience) in his 30s, told me about how he had screened providers for months after moving to Los Angeles a year ago. He had visited four different providers in person; all were unwilling to prescribe him the same hormone regimen that he had been using for years back in Oregon. He developed a line of questions to screen providers by phone:

> So, first question, “Do you work with intersex people?” “Yes.” Second question, “Do you prescribe testosterone?” “Yes.” … “Will you be okay with trauma for intersex people, cause there’s a lot?”

Trystan told me that he added the last question about trauma after visiting a provider who had agreed to work with him only to suggest that he would need to come to the office every two weeks to have hormones administered in person. Realizing that the pattern of control was rehashing his past experiences of medicalized trauma, Trystan worked to reverse the field by developing a screener to assess providers and disqualify them. Speaking to a potential collective benefit, Trystan hoped the screening process might increase awareness of some of the needs and risks facing intersex people among providers.

Across the interviews, participants spoke about screening out providers when they “caught a sense” or detected pathologizing or patronizing attitudes, racism, homophobia, or did not get a “good vibe.” This was particularly apparent in relation to seeking gender-affirming care. For example, Brody (he), a white transgender person in his early 60s, told me a story about his approaching his general practitioner to start testosterone. He explained:

> I told her that I was transgender. She said, “Oh, do you want to see a psychologist?” And I said, “No,” and I knew she was not the person to talk to, end of story. She was a dead end. I needed to find a trans-friendly provider.

In addition to explicit forms of screening and opting out after a troubling interaction, processes of tactical utilization were also implicit and revealed the ways participants searched for providers in the first place. Participants formulated criteria and looked for providers where they anticipated there would be fewer problems, or as Travis put it, “more common ground.” Travis (she), a Filipino gender-nonconforming person in her early 20s, called this process “filtering people out” as she walked me through her own deliberations in trying to find a trauma therapist. She said she had been looking through professional bios online, and her process revealed some of her criteria:

> Do the people understand, one, me being queer. Two, me being gender nonconforming. Three, me being like – a victim of sexual assault. And then, also being Filipino. Do you understand me navigating those identities within the aspect of being a person of color who has a culture that's very religious and conservative?

Filtering people out was a largely hidden process (in that it is concealed from providers and heathcare systems) and mundane (in the sense that many healthcare seekers in general use some version of this strategy). Tracing this process among participants in this study revealed how tactical utilization fuels demands for transgender-specific services, but also for a more racially, culturally, and gender diverse healthcare workforce and alternative forms of care practice. Every participant that I interviewed had looked for and utilized a transgender-specific or LGBT clinic or specialized provider in their lifetime. Many looked for and felt they would receive better care from other trans or queer people (although few had ever had a trans provider). They sought information online, asked friends, and called organizations and insurance companies asking about “trans-friendly” providers. Participants traveled far out of their way and scheduled appointments months ahead of time in order to continue to see these providers, some telling me it was the only place they felt safe accessing care (implicitly refusing services in other settings). When I asked Kamal (they), a Black genderqueer person in their mid-20s, a bit more about why they looked for a "trans-affirming provider" when they moved to Los Angeles, their answer revealed a set of expectations.

> Saying that you are providing trans-affirming care lets me know that the people that work in your office have worked with trans folks, and know how to ask the appropriate questions, and know how to provide gender-affirming care. I'm less likely to encounter transphobia in this place. There might be more data around trans health care in this place that I can ask about and receive. And I'll be taken care of, like you will be intentional about the way that you engage with my body, and that, for me, is really, really important.

Like Trystan and Travis, many other participants spoke about trauma. They paid attention to power dynamics including, as Kamal put it, the ways providers "engage with my body." They assessed whether providers were informed and demonstrated attentiveness to the effects of trauma on experiences in clinical interactions.

Some participants told me they looked for providers who shared their cultural or racial background or were "culturally aware" in relation to past negative experiences or expectations of receiving better care. For example, Isaac (they/he), a two-spirit Indigenous person, opted out of services in an LGBT health center after a white doctor in the clinic dismissed their interest in using traditional medicines. They told me, "I grew up with my mom making herbal remedies … when she's telling me that it doesn't work, it's kind of like she's being disrespectful, being racist." They asked friends for recommendations and found a provider who worked regularly with trans people, was a woman of color, was knowledgeable about traditional medicine, and was open about some of her own critiques of Western medicine.

Participants also spoke about the tactical utilization of services, such as utilizing certain services while refusing others. In primary care settings, this was most often discussed in terms of sexual and reproductive health in which participants clocked clinicians' discomfort and said they did not find healthcare providers to be particularly credible sources of information. A few participants told me that while they wanted to utilize some general care services, they would never consent to routine cervical cancer screening.

Opting out did not imply a divestment from health care, rather many spoke about exploring and developing alternative strategies for addressing health needs. Jim (he), a Black FTM in his late 20s, said he made a conscious choice not to talk to medical providers about reproductive health or his interest in getting pregnant in the future. Acutely aware of the inequities for Black pregnant people in medical settings, he said he literally feared for his life. Jim said that if he did decide to get pregnant he would turn to "trans and queer doulas and birth workers… especially Black ones who have a decolonized, intentional understanding." Speaking to his knowledge of alternatives as rooted in trans communities, Jim told me, "I know other Black transmasculine people who've experienced this," going on to describe this not as a "service" he could utilize but a movement he could get involved with. In several cases, participants spoke of gaining a sense of community, as well as bodily autonomy and control over their own health care decision-making, by limiting their contact with medical services and connecting with other forms of health and healing. In fact, several participants had pursued formal and informal training in alternative forms of care (e.g., doula-ing, herbal medicine, emotional release) and sought to offer them to other trans people.

Antagonizing erasure: Overriding assumptions, “setting the tone,” and refusing stigma

Antagonizing erasure refers to efforts to prevent and undermine providers’ authority to assume their gender, scrutinize and try to sort out their gender, and enact stigma in relation to uncertainty or anti-trans bias. Participants’ ways of managing gender categorization were highly dependent on their social positions including their gender identity and how their gender was generally perceived, and the kinds of care they were seeking. They tailored and timed the delivery of information, offered additional information or limited the scope of inquiry, set boundaries, and intentionally unsettled binary gender systems.

A common way that participants antagonized, or challenged erasure was by overriding gender assumptions. A quite literal example was a participant who told me about crossing out and writing over binary gender options on a medical intake form. Stories were rife with gender symbols, from pronouns (e.g., he/she) and honorifics (e.g., Sir, Ma’am), to “women’s services” and “men’s” testing kits, to lab test reference ranges and color-coded patient files, gendered garments and gowns, and an M or F on a hospital wristband. As participants anticipated how gender would be imposed onto their bodies, they strategized about how to circumvent assumptions, avoid misgendering and confusion, and steer providers toward more accurate recognition. Some called ahead, asked for special notations to be added to their medical files, wrote in large print, or used a range of nonverbal cues. Otto (he), an African American transman in his late 20s, took to writing “transgender” and “FTM” on his intake forms. Although all his records and paperwork said he was male, Otto’s providers were more likely to assume that he was a trans woman than a trans man. In a story exemplifying the nature of the unrelenting work to override assumptions, Otto told me about a call he had using a non-emergency nurses’ line the previous night:

> I just needed some advice… The person who picked up the phone, they kept going, “Ma'am.” And the first time I was just like, "Okay, it's Sir.” And then she was like, “Oh, okay, ma'am.” I'm like, “it's Sir?” And she's like, “Oh, okay Ma'am.” I'm like, oh my god. And she did that five times until I had to say, “I'm not a girl!” And she's like, “Oh, sorry.”

While this kind of routine was common for some and crossed into many social and institutional spaces, others noted that healthcare services sites were one of the only places where complete strangers could come to know they were trans (or intersex) because of providers’ prerogative to access personal information, medical histories, and their bodies. The process of “setting the tone” was elaborated from a story Clark (he) told me about another emergency room visit. He was there for a leg injury but was unsurprised when providers started to dig into unrelated information in his medical record. In this story, his wife is with him, and he tells me how bringing a companion is one of his primary self-defense strategies:

> So, they were like, “why are you on testosterone?” And [my wife] jumped in and was like, “He’s trans and it’s okay” and, you know, “What other questions do you have?” …It set the tone, we’re not going to play this game, you know what I am saying? I’m here to do one thing, we don’t need to have any other questions about personal shit.

This “moment,” as Clark described it, was a recurring plot. As providers laid claims for clarity and explanations, participants variously redirected, interrupted, and diverted them. In Clark’s account, for example, saying “I’m trans” was not as much about a personal disclosure out of comfort, but a response to and product of erasure. Even participants who did not use the term "trans" for themselves in other settings, said they might use it in a clinic. Using "trans," in the sense of setting the tone, served to reconfigure assumptions, abbreviate an interaction, mitigate further scrutiny, and usurp providers' authority to try to "figure out" or "make sense" of their body. Setting the tone was a strategy for diffusing, and potentially transposing stigma. Mahlik (they/he), for example, told me a story about being asked to remove their shirt for an echocardiogram. Anticipating that providers might start to speculate about their body, Mahlik said they "just owned it":

> I was like, "I just want to let you know that I'm trans and I have a chest." … I just put it out there, instead of this shock factor that will make me feel super uncomfortable, like, people looking at me in a weird way. I just put it out there. It makes them feel uncomfortable instead of me feeling uncomfortable. [laughs]

In Mahlik's account, announcing "I'm trans" recuperated their power over sense-making (by "owning it"), and had the potential to shift the burden of feeling uncomfortable back onto healthcare workers. The possibility that owning "trans" might transpose stigma and discomfort back onto a provider is seen here as a product of collective protection in laboring for social currency and belonging.

In another register, Brody (he) said he looked for moments to talk about being trans often overriding assumptions that he is a cisgender man. Brody said he felt "privileged" to do so, both speaking to a sense of lower risks for retaliation (e.g., white, retired, economically secure, consistently perceived as a man) and about having pride in his identity which came later in life.

When an optometrist, for example, asked Brody about why he took testosterone (something Brody had voluntarily offered up on his intake form), he was enthusiastic to make a connection with a provider who seemed to have not thought twice about asking the question. Offering up the conversation was, for Brody, a way to set the tone, refusing stigma through adopting a sense of being an ambassador or representative group member.

Processes of antagonizing erasure were also palpable in subtler, even covert, responses to hegemonic gender norms. When faced with the onus to offer clarity, give language, or explain themselves, some refused by omission. Participants who said they were generally always perceived to be cisgender men left out requested information about taking testosterone or surgical histories, refusing what they deemed as an overreach into irrelevant information or, as one person called it, "extracurriculars." This was not a matter of compliance with normative binary gender as much as it was playing to gender norms to gain advantages. Liam (he), a white male in his early 30s explained, "I'm not going to put evidence of that on my forms because I just don't want them to factor that into my care at all." Isaac (they), also concerned about unequal care, said they would routinely shave their facial hair and raise their voice up in healthcare settings. Describing the strategy as "shapeshifting," Isaac told me:

> I'm molding to other people and I'm aware of that, but it's for my own mental health and emotional wellbeing. … I'm also protecting myself as ironic as that may sound.

Shapeshifting, in this sense, was also a process of recuperating sense-making power, while working within the confines of binary gender expectations. Much like cultural code-switching, shapeshifting was a process of amplifying certain cues while disguising others.

Participants raised or dropped their voices, planned out their outfits, and shaved or filled in beards. Jacob (he) told me about bringing a "wing woman" with him to "women's" health care settings to pose as the patient in the reception area to avoid confusion. Processes of "shapeshifting" were also relevant to the ways participants played to the norms and expectations of "transgender" men (e.g., binary gender identity, masculine gender expression, heterosexuality, desire to be undetectable as a trans person), or what Johnson (2016) elaborates as "transnormativity." This was particularly relevant in the context of accessing trans-affirming medicine, which participants described as especially contingent on one's appearance and ability to meet set criteria. Jim (he), for example, said he knew all the standards of care for accessing trans-affirming surgery, and a friend had warned him about the peculiar requirements set up by his Health Maintenance Organization (HMO). He told me he wore a tie, knowing that he would be asked to describe his outfit while a provider entered his description into an electronic medical record. He said he dressed, but also acted strategically, knowing not to be "too feminine," but also, to convince providers he needed treatment but was "stable enough" to make the decision.

Processes for antagonizing erasure were also aimed at intentionally unsettling gender norms and categorization, including "trans" categorization. In some respects, asserting a nonbinary, genderqueer, or nonconforming identity in healthcare settings was exemplary of this, at least linguistically. However, processes of intentionally subverting cisnormativity were not necessarily about making new categories but making normative binary categorization appear unnecessary and unnatural. Orion (he), a white transsexual man in his late 30s, said he just laughed after he told a medical receptionist that he couldn't complete the part of the form relating to his last prostate exam when she insisted it was of utmost importance for men's health. They went back and forth a few times, he said, each getting a bit more assertive. Rather than using the term “trans” to explain why he could not complete the form, Orion said he just left her to guess why he might not have a prostate gland. Ivan (they/she), a white genderqueer person in their 40s who grew facial hair without exogenous hormones, said that they had received unsolicited recommendations from providers about removal options. Rather than explaining her genderqueer identity, she had simply responded that she liked her facial hair, hoping to challenge the underlying sexism. Ethan, (he), a white trans man in his early 20s, said he was also not interested in fixed ideas of what “trans” means. In his routine sexual health screenings at his university’s health clinic, Ethan told me he was always faced with telling the healthcare worker, in an open reception area with other students, that he would need “the other” testing kit. In response, Ethan told me:

> I like to do casual drag, so showing up to my tests in what would be considered traditionally feminine clothing with a whole bunch of facial scruff, and male listed on my profile and listing myself as “MSM” and still having to ask for the vaginal swab. That sure means a lot of things! I don't know how much of a change it's making, but if it's at least normalizing it for one nurse, then it's normalized for one nurse. And it’s one more nurse than it was before!

For Ethan, refusing expectations of a trans man made room for “meaning a lot of things.” Unsettling gender norms (both cisnormative and transnormative), participants antagonized erasure by flaunting the limitations of a two-gender system in ways that both made “trans” more spacious and more possible (or less impossible) and making two gender categorization less possible, or more difficult.

Redirecting care: Asserting authority and advising practice

Redirecting care explains processes participants used to develop and assert authority over their own care and undermine norms of provider authority. Anticipating trouble, participants cultivated a range of proficiencies for directing their own care, and, at times, advised providers on how to care for trans patients more generally. Participants conducted independent research and sought information and recommendations outside of medical settings, from mainstream and transgender-specific sources. They “fact-checked” the advice and recommendations they received from providers against information in community networks and used community information to substantiate their directions in care, making community knowledge an essential self-defense tool. For example, Dree (he) a Latino trans man in his 30s, had been told he would need a diagnostic test that would involve catheterization to gain a referral for a hysterectomy. He planned to schedule the test but was anxious that it would be painful and degrading. Dree’s girlfriend encouraged him to look at transgender community health forums online. Becoming confident that the test was unnecessary, Dree went back to the specialist to refuse the test, leading the provider to admit (or learn) that the test was not, in fact, a requirement.

Asserting authority to direct and redirect interactions with providers was especially discussed in the context of gender-affirming care. Practices involving more direct assertions of authority tended to track with participants who had more access to community networks and information, and to some extent, social privileges (e.g., older age, access to education, whiteness, male gender identity). Dree, for example, recounted stories from an earlier period of his life when he was homeless, uninsured, and, in his words, “dying” of drug addiction. Dree contrasted this period with how he now feels, saying he commands more authority because he is housed, employed, and can be perceived as a white man who “has his life together.” Other participants felt they had gained more authority in clinical encounters as they got older, which some also tied to having had access to gender-affirming care and, relatedly, being perceived as a man. Max (he), a white "transdude" in his early 30s, summed up these connections, telling me:

> I was just over the moon grateful for being able to get hormone therapy the first time…. So, I didn't mind how they treated me, so long as I could get what I needed, right? But now, as a person, I'm more likely to object to things.

In asserting authority, and "objecting to things," participants drew on lived experience and embodied knowledge. As Kamal (they) put it, "trusting my own body" was a potent proficiency in rivaling some of the sedimented dynamics in provider-patient relations. This was something Kamal told me that they had strengthened over time and directly contrasted with the notion of provider expertise, going on to say:

> I've finally come to a place in my life where I feel really secure in who I am and secure in my awareness of my body, and changes in my body – even specific to being on testosterone. I'm looking at my body changes every day, and to not have that validated in a setting where this [provider] is supposed to be an expert, is just disheartening.

Participants developed and performed proficiencies to assert expertise. Liam (he), a white man in his early 30s, said he grew up poor and completely unaware of trans people but had amassed considerable knowledge through community networks and as a university student. He studied the history of pathology and had practically memorized the standards of gender-affirming care.

When his healthcare insurance company unexpectedly required him to get a second medical authorization letter for an upcoming surgery, he said that he was livid and “came in hot.” He told me:

> I went in there very candidly being like, “I'm getting the surgery. I absolutely am qualified to get the surgery. And I just need you to write me a letter.” Like, “that's all I need from you. That's the extent of our relationship. I'm fine. I have people to care for me afterward. My mental health is taken care of.”

The therapist was sympathetic, Liam said, and they worked together on the letter, but he said he blamed the coercive system that had both set them up as antagonists and valued her opinion over his. Collaborations with providers, as in Liam’s case, supported processes of directing care and extending benefits to others. Liam said he frequently used his skills to advocate for others, asserting authority as a surrogate (e.g., making calls for others, equipping others with language to use) and helping others increase their expectations in healthcare settings.

Participants sometimes used the term “educate” to describe their responses to inappropriate and hostile interactions. Mahlik (they/he), for example, told me that they “took the time to educate” when a provider used a derogatory term for them, but the doctor doubled down and referred to his credentials to say he knew best. As in Mahlik’s account, there were many examples of where efforts to educate were not well received, and, at times, precipitated further harm. However, other times, advising providers felt more mutual, useful, and even desirable to participants. Advising practices, in this context, were those that tipped the balance of power toward patients and had the potential for co-learning and collaboration. They included participants choosing to offer up information, but also being sought out for their input. Dree, for example, said that he was glad when a preoperative care nurse asked if he would be willing to help her out with a paper for school. He went on to tell me that he hoped by doing so, there might be a collective benefit for trans people, saying:

> I agreed because she wants to take the time to learn. I don't really deny opportunities to do that, you know? I feel like I can make a difference in a very small way. And those are the ways that I can do that.

Participants said that when their advice or feedback resulted in changes, it created openings and increased their confidence in directing care. For example, Mahlik (they/he) said they suggested to healthcare workers at a clinic that they visited regularly that staff could just use their first name instead of an honorific ("Sir," "Ma'am"). When staff picked it up, he began to take more steps in directing his care. These accounts tended to apply most to situations where participants and providers could build trusting relationships over time. Advisement practices in longer-term patient-provider relationships to cultivate both provider and patient knowledge which, in turn, had potential collective benefits for trans communities. For example, when Orion (he) told me about how much he loved his current primary care provider, I asked if she was a transgender health care specialist. He told me, "I am kind of making her become that person. I keep sending people to her." In this sense, advisement practices work to expand the networks of potential trusted care providers and simultaneously work to increase individual protection, if not greater satisfaction, with care provision.

Pursuing accountability: Exposing harms, making complaints, and boycotting

Pursuing accountability refers to processes used to draw attention to harms that were caused and to urge providers to respond or take responsibility. Some participants made direct complaints to their providers, although they perceived risks in doing so and some of these stories resulted in escalating tensions and denied care. Most often, strategies for pursuing accountability in one-on-one interactions with providers were subtle, indirect, even artful. For example, participants might simply ask "why" when providers asked for information or wanted to conduct exams or tests (e.g. "why is that necessary?) with the purpose of exposing unnecessary or irrelevant requests. They also observed through efforts to correct assumptions and misinformation. For example, Kamal (they) told me about a provider that had conceded she did not have experience working with trans patients but that she wanted to learn. This had created an opening for advisement. When Kamal saw that she had put the word "transsexual" on their medical records, they made a point to ask directly: "Hey, can you change that?" Yet, corrections yielded mixed results; in Kamal's case the doctor claimed that this was the only option she could select, and Kamal chose not to return to this practice. Yet, even when corrections were unsuccessful in the moment, participants hoped for a potential net effect in which providers became activated to change protocols and practices.

Most direct complaints were made after an interaction with a provider and in writing. Participants filled out feedback forms, filed grievances, and wrote "tersely-worded emails." They asked for a response, for resolutions, and even apologies (although rarely received them). Some participants utilized formal administrative systems. However, examples of escalating requests for accountability to the institutional level were notably thin and often relied on external responses. Even in blatant cases of discrimination, most did not take a complaint. Pursuing accountability through institutional channels requires at least some degree of institutional trust. One participant, who was lawyer, summed up a stories coolly offering, “I don’t know what rights really protect us, we're already like freaks, you know?” Only participant that I interviewed spoke of successfully filing and settling a gender-discrimination case, and it was not against a medical provider but a private health spa. This participant, who was white and genderqueer, said that they would have never considered taking the case if not for a friend’s encouragement, noting that their friend was “a straight white guy, of course,” tying the strategy to racial and gender privilege.

Alternately, forms of boycotting did not rely on a response from a provider or institution. In this context, boycotting means giving notice to other people that a provider or clinic was untrustworthy and encouraging others to avoid them. No one used the term explicitly, but many did learn from friends or online social networks about which providers or clinics to avoid. In an explicit example of the strategy, Clark (he) told me a story of being flatly refused a surgical consultation when the provider learned he was trans. His immediately response was to inform others, saying:

> Before we even got to the car, I made a call to my primary care provider [at a trans-specific health clinic]… and let them know, “look, don’t send any more trans men to this OBGYN, because this is what just happened!”

Boycotting epitomizes collective protection. Participants used the strategy with the explicit goal of protecting others and the scale of impact relies on community communication networks.

Discussion

This study analyzed the healthcare stories of transmasculine participants in a community health justice initiative to explore how patients work to shift power over the terms of care. Prior studies based on similar accounts have focused primarily on institutional conditions of mistreatment. Doing so has provided for many potent diagnoses of why healthcare services are unsafe and inequitable for trans people, and especially how epistemic erasure (Bauer et al., 2009; Namaste, 2000) produces conditions of institutionalized neglect, care mismanagement, stigma, and structural violence (e.g., Davis et al., 2021; Knutson et al., 2016; Poteat et al., 2013). *Compelling care* describes a social theory in which decentralized acts of patient self-defense reflect and marshal forms of collective action and protection.

Participants prepared for a fight in health care systems because of knowledge exchanged in trans communities, but also in relation to broader critiques of health care institutions. Participants engaged in self-defense strategies based on how they assessed their safety, interactions with providers, and how they expected to be received, at the intersections of multiple social identities. Racism (and white privilege) especially influenced participants' expectations of care and self-defense strategies. For example, more Black participants and other participants color (but not only) spoke about limiting contact with medical service providers and finding alternative sources of care, while more white participants and those perceived as men (but not only) spoke of providing explicit directions to providers and engaging in advising practices. While this analysis is provisional, this would suggest that trans people of color and people with less conforming gender identities may be viewed by providers as less trustworthy advisors, creating additional burdens and requiring different strategies for asserting power over the terms of care.

Trans people routinely report delaying health care due to concerns of mistreatment (Hughto et al., 2018; Kcomt, 2020). Racism in healthcare services has likewise been associated with patterns of delayed care (Ben et al., 2017). While medical mistrust is understood as a protective response in relation to institutional racism (Berkert et. al., 2019), a robust analysis of medical mistrust as a protective response among trans people is underdeveloped. *Compelling care* theorizes how and why mistrust, or skepticism, is not only protective but a foundation for intervening in institutional power. This analysis offers an antiracist reframe to some of the existing pathologizing language imposed on trans people's healthcare-seeking behavior (e.g. "rejection sensitivity," "hypervigilance") and complicates the tendency among health researchers to treat services as a universal good for trans people. If, as this study suggests, preparing for a fight is instrumental to building power over the terms of care, we might ask how to strategically develop skepticism rather than how to mitigate against it. For example, scaling up political education efforts alongside community health knowledge exchange efforts online or situating patient advocates within trans-led organizations are strategies that invest in trans patients in broader efforts to redress institutional harms.

A theory of compelling care rewrites understandings of what "transgender health care" is or means in a time in which advocacy groups, medical experts, researchers, and policymakers variously tussle over its regulation. For participants in this study, being "trans" in clinical healthcare was not merely a byproduct of seeking gender-affirming healthcare services (although it was still that) but of providers' prerogative to scrutinize and assign gender to patient bodies.

Paine (2018) previously described the pattern in which healthcare providers react to the "disruptive embodiments" of trans and gender nonconforming patients by trying to sort them into binary biomedical gender schema. In this study, participants invoked "trans" as a kind of symbolic protection against binary categorization. While the term "trans" was wholly insufficient to describe the lived gender diversity among participants in this study, being "trans" in healthcare settings offered a language for refusing assumptions of binary gender. This strategy of defense relies on and contributes to the collective identity work of trans social movements. The sense of being part of a collective "trans" experience or "having friends like me" was also tied to how patients made claims for better care. At the same time, the choice to not be "trans" and refusing to explain non-conforming information in one's medical record or history (as in Orion's case with not completing the form about his prostate) or to even flaunt transnormative scripts (as in Ethan's case of "competing" gender information and performance), allude to possibilities for solidarity practices that might arrive at their political potential because of the ways that being "trans" has gained traction categorically in medicine.

As healthcare institutions are increasingly compelled by law and society to mark themselves as inclusive and embracing of diversity, provider education and nondiscrimination policies are common refrains for reform. Given statewide legal protections against discrimination for trans people in California, it was notable how few tools participants felt were at their disposal to hold providers accountable for harm. Many feared, and some experienced, retaliation in rebutting providers and directing their own care. Thus, while it is useful to know, even relish in, the ways that trans people are resilient and creative, and navigate, maneuver, and resist dehumanizing and dangerous institutions, it is only through recognizing how these strategies can and do help build collective power and accountability that we might shift from collecting edifying accounts of resilience to theoretical developments that can drive social change. The theory of compelling care is one such opening.

Researchers and advocates concerned about the mistreatment of trans people in healthcare settings have focused heavily on the mitigating role of providers. This study joins and extend calls from the Transmasculine Health Justice: Los Angeles initiative and recent research efforts focused on transmasculine healthcare self-advocacy invest in patients (Agénor, 2022; Perez et al, 2021; Seelman & Poteat, 2020). Promising approaches based on this study might include patient-driven referral networks, community-led patient rights education and legal advocacy, storytelling projects for trans audiences (i.e. not only for training providers or advocacy purposes). In a market system, demand for transgender-specific health care sites, trans (and especially trans BIPOC) care providers, and culturally specific care practices are strategies for compelling care but require vigilance to resist their commodification for the economically privileged. On the other hand, efforts to increase the quality of publicly funded healthcare and strengthen institutional accountability mechanisms are strategies with benefits for marginalized patients broadly.

It is worth noting here that most of the data used in this study were collected before or at the start of the coronavirus pandemic. Recent shifts toward telemedicine may transform how self-defense strategies are engaged, particularly in the context of restricted physical contact and the potential for forms of sousveillance (Mann, Nolan, Wellman, 2002). Future research might better address this, as well as extend the theory of compelling care to consider how trans people engage in similar (or different) strategies in other institutional contexts or investigate how forms of solidarity among otherwise stigmatized patients are expressed at the level of the individual encounter.

Conclusion

This study offers redirection to a growing tendency in research to highlight the humiliating, exclusionary, and abusive conditions that trans people endure in various healthcare service settings, by taking up the question: how do we *make* healthcare more comfortable for *us*? Participants in this study grappled with their historical and representational role as trans patients as they negotiated for their own care with other trans people in mind. Compelling care reveals how in the relations between individual acts of self-advocacy and the collective processes that underscore them, lies the potential to further tip broader relations of clinical power. The theory renders patients as visible as actors within a broader set of negotiations that social movements are making on U.S. healthcare systems.

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Chapter 3: Community care: The social care work of transmasculine community building

Abstract

This study focused on relational and community-building practices among transmasculine people as constitutive of transgender health care outside of institutional medicine. The study intervenes in recent research efforts to measure the health benefits of social connections between trans people and tend to treat the concept of "trans community" as self-evident overlooking it social and political construction. This study was conducted as part of a trans-led health justice initiative in Los Angeles County, California and draws on 26 in-depth interviews with social diverse participants. Guided by constructivist grounded theory and prioritizing the experiences of Black and Indigenous participants and other participants of color, I identify *transmasculine social care work* and outline some of the theoretical underpinnings of community-generated health interventions that built on and facilitated of social and political independency.

Introduction

> Trans people have a long history of organizing our own health information and care practices. This is happening everywhere: in conversations between friends, in community organizations, on social media, and in activist and academic literature. We hope to contribute to and lift up these forms of collective knowledge and community wisdom. We find inspiration and power in the work of our trans siblings and ancestors. We align this work with other forms of liberatory self-care and mutual aid strategies.
>
> Transmasculine Health Justice: Los Angeles, website, 2021

Today's proliferation of transgender community-based organizations, political advocacy groups, clinical health services, social media networks, cooperative housing projects, sports teams, choirs, and scholarly journals was barely conceivable two decades ago (Nownes, 2019). This is not to say that trans people (or those living outside of assigned gender roles) did not exist, find each other, strategize for survival, or have fun together long before. Indeed, the circulation and consolidation of the term transgender (or "trans") in the late twentieth century was possible because of a longer history of people coming together to reckon with a sufficiently similar set of oppressive circumstances (Stryker, 2008). It is to say, however, that trans-led organizations and formations are diversifying and growing in their spheres of influence (Trans Justice Funding Project, n.d.) and that the sheer number of people who identify as transgender is on the rise (Herman et al., 2022). As a social identity and liberationist concept, "trans" has provided a pathway, and a literal search term, to self-recognition, belonging, kinships, politics, and even love (Awkward-Rich & Malatino, 2022; Greene, 2021; Pearce, 2018; Shapiro, 2004).

From another vantage point, however, the idea of a trans community has been imbued with aspiration, figurative, and imposed. As a social welfare scholar, I am specifically interested in how "trans community" is abstracted as a salve to myriad social and health inequities. As public debates have raged over whether and when trans people should be included in language, sports, statistics, bathrooms, health care, and more, trans advocates increasingly wager claims for rights on crass calculations of premature death. A quick perusal of recent news headlines is demonstrative (e.g., "Trans health care is a 'matter of life and death' doctors say," "'Terrible time for trans youth:' new survey spotlights suicide attempts — and hope"). Yet, death-centric discourses have also driven fear and stigma in trans communities, and advocates' efforts to formulate effective responses have sometimes hastened the very inequities they aim to ameliorate (Snorton & Haritaworn, 2013; Westbrook, 2021). It is in this paradoxical context that social and health researchers have increasingly hailed community. Community stands in for a much-needed "positive" thing about being trans (Riggle et al., 2011), a source of trans joy (Shuster & Westbrook, 2022), and a reason to live on (Moody et al., 2015). Though not at all a hollow gesture, it is nevertheless a kind of "romantic" one (Joseph, 2002) in the sense that a imagined community is assigned the formidable task of ameliorating state-sanctioned violence and neglect, daily indignities, and political backlash.

Researchers have already attributed numerous social and health benefits to being connected to a trans community, including a sense of belonging (Barr et al., 2016), social support (Johnson & Rogers, 2020), better mental health or reduced negative mental health symptoms (Johnson & Rogers, 2020; Pflum et al., 2015; Sherman et al., 2020), healing from trauma (Mizock & Lewis, 2008), connections to health care services (Sherman et al., 2020), increased civic engagement (Billard, 2022) and social change activism (Singh et al., 2011). In fact, researchers have found that simply knowing that another trans person exists may have health benefits, including reducing fears and anxiety about the future (Testa et al., 2014), and that emotional support from and a sense of responsibility to other trans people may play a role in suicide prevention (Kia et al, 2022; Sherman, 2020). Yet, researchers have also come to contrasting conclusions, suggesting more neutral psychological effects of connections to trans communities and negative stressors tied to engagement in activism (Breslow et al., 2015; Valente, 2020). As Patricia Hill Collins (2010) has summoned sociologists to consider, the ubiquitous and versatile term community is too rarely interrogated. The concept, which tends to evoke deep feelings, can generate emotional connections and rally action for social change but is also tied to symbolic boundary construction and the creation of racial, gender, class, and other social hierarchies (Collins, 2020).

In this study, I build on what Bailey (2009) conceptualized in his ethnographic study of Detroit's Black queer ballroom scene as cultural *intra*ventions in the HIV crisis, as strategies that are "conducted and sustained through practices and processes within at-risk communities themselves" (p. 255; attributing the term "intravention" to Friedman et al., 2004). I aimed to denaturalize the health-promoting role of "trans community" by delving into the relational practices and processes that build trans communities and theories of health produced by them. The study emerged in connection to my involvement in community-based research and organizing effort that was led by and focused on transmasculine[1] people in Los Angeles County, California Los Angeles is a longtime hub of trans cultural life, political organizing, clinical services, and what Greene (2021) calls "transgender kinship organizations" in reference to forms of social provisioning among trans people that have increasingly formalized as non-profit service models. The modicum of public health funding for transgender people in Los Angeles, and elsewhere, has prioritized a narrow set of health concerns (mostly HIV) among transgender

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[1] I use the term transmasculine throughout with consistency to the local initiative. It was intended as a tactical category to speak broadly to trans people who were assigned female at birth, and with the recognition that many do not use the term for their own identity. For the purposes of this study, it included (and was not limited to) people who are two-spirit, trans, trans men, non-binary, masculine of center, men, male, intersex, genderqueer, gender non-conforming, ftm (not as an acronym), and female-to-male (FTM).

women. Although transmasculine people have long participated in community organizing efforts related to HIV prevention and in social provisioning in trans kinship organizations, there has been little attention to efforts to address social care needs among transmasculine people.

The politics of community connectedness and health equity

Social connectedness is a well-established social determinant of health associated with reduced health problems and longer life expectancy (Berkman & Syme, 1979; Holt-Lunstad et al., 2015; Leigh-Hunt et al., 2017). One of the ways that social stigma undermines health and life chances is that it limits access to the benefits of dominant forms of social belonging (Hatzenbuehler et al., 2013). Social stigma for transgender people is a byproduct of hegemonic gender norms structuring dominant modes of social organization and belonging (e.g., heteronormative families, whiteness, geographic neighborhoods, hegemonic Christianity). Diamond and Alley (2022) explain how limited social safety lends to patterns of "chronic threat vigilance" contributing to health inequities.

Researchers seeking to identify some of the social and health benefits of being connected to a "trans community," draw largely on social psychological theories and specifically Meyer's (2003) Minority Stress Theory (MST). From this perspective, being connected to a lesbian, gay, bisexual, and transgender (LGBT) community can buffer stress caused by social stigma because it provides for alternative forms of belonging and affiliations with individual and community-level mutual benefits (Frost & Meyer, 2012). The theory of community connectedness was premised on observations of predominantly white (and cisgender) gay and bisexual men but has been adopted in research and clinical services models for trans people and other gender minorities (Hendricks & Testa, 2014). While Frost and Meyer (2012) suggest that the concept of an "LGBT community" is sufficiently capacious for examining the affiliations among subgroups, researchers have recently trained measures to ask about connectedness to "trans community" specifically (e.g., Plfum et al., 2014; Sherman et al, 2020).

Despite the growing interest in measuring if and how being connected to a trans community has health benefits, far less attention has been paid to community building and the structures that enable and constrain a sense of connection. Treated as self-evident, the conditions in which trans people come to rely on each other is too often naturalized. Yet others have insisted that the labor of community care work, emotional support, and mutual aid practices among trans people be viewed in more clearly political terms (Malatino, 2020; Piepzna-Samarasinha, 2018). From this perspective, trans community building is seen more clearly within an undue racialized and gendered burden of care labor in a "care crisis" (Nakano Glenn, 2010) or "care deficit" (Chatzidakis et al., 2020) produced by the neoliberal gutting of social welfare infrastructure. Yet trans studies scholars have simultaneously urged readings of community-building practices as emergent transformative politics. To this end, theorizations of care work among and between trans people have especially focused on the disproportionate burden, and therefore the care work politics and practices of trans women and femmes of color (e.g., Aizura, 2018; Greene, 2021; Malatino, 2019; Malatino, 2020; Hsu et al., 2022; Lundy-Harris, 2022; Marvin, 2019; Piepzna-Samarasinha, 2018).

This study took shape through my involvement with Transmasculine Health Justice: Los Angeles (TMHJ:LA) initiative which aims to build power among transmasculine people to envision, direct, and develop strategies for health justice (see Perez et al., 2021). The effort is rooted in the organizing strategies of Gender Justice Los Angeles, which has organized transmasculine people in Los Angeles for nearly two decades (Nownes, 2019) and is currently led by and for Black people, Indigenous people, and other people of color. The term "health justice" was used by the group to situate its work within broader intersectional struggles for gender, racial, and economic justice. "Building community" is a central motif of the initiative's pursuit of health justice. It is within this context, that I aimed to develop deeper conceptual understanding of the ways transmasculine people build relationships and communities and develop practical forms of support. Drawing on the established links between community connectedness and health, the primary aims of this study were to explain some of the social processes through which transmasculine people come to feel connected to trans communities and illuminate the factors that enable and constrain these connections. While this study engaged a multiracial group of participants, my analytical approach prioritized the experiences and social practices engaged by Black and Indigenous participants, and other participants of color, in alignment with the community initiative broader mission for health justice.

Methods

I used a constructivist grounded theory (CGT) research design as outlined by Charmaz (2014). CGT is a data-driven approach to developing theoretical explanations of social processes. The underlying assumption of the method is that social phenomena can be observed in the ways people act and the meanings that people derive and and produce through interactions with others (Blumer, 1969). To exploring how participants made meaning of their relationships with other transmasculine people, I conducted and analyzed in-depth interviews through an iterative process. Inductive analyses were used to elucidate observations into higher order constructs and an abductive process was used to test the analysis against new observations (Charmaz, 2014).

Data collection

Inclusion criteria for the broader initiative included being transmasculine (assigned female at birth), age 18 or older, and living, working, or receiving health services in Los Angeles

County. Participants responded to a recruitment message that was circulated through the social networks of TMHJ:LA participants, as well as print materials that were distributed to unaffiliated organizations, local businesses, and health care clinics. I clarified that I was a graduate student and that the interviews were part of my dissertation research project. The study protocols were approved by the University of California, Los Angeles (UCLA) North Campus Institutional Review Board (IRB#17-000134).

Most interviews were held in-person and at a location of the participant's choosing, or my offering, including participants' homes and workplaces, public libraries and parks, private offices at two community-based organizations, and on UCLA's campus. Due to social distancing restrictions in response to COVID-19, the last 8 were conducted through video conferencing. I followed an open-ended question guide and each interview started and concluded with an open-ended question about participants' priorities related to research on transmasculine health. Situated within a broader research context, in-depth interviews explored a range of health-related themes. Some of the questions that were most useful in the development of this study included those related to: identity terms and how people arrived at the terms they preferred to use for their gender identity; a sense of belonging to a trans community; forms of support participants had received and offered to trans friends; where people received information that they felt was most relevant to their health; and a question about what participants thought "we" (the initiative, or as transmasculine people) could do to build community and meet the health needs of young transmasculine people. At the end, I asked what felt missed or absent from our interview that was important. In some cases, this led to a much longer conversation. Recorded interviews lasted between 50 minutes to two hours. Participants received a $50 incentive for their participation.

Data analysis and theoretical saturation

I manually transcribed all audio recordings verbatim and wrote field notes. Seven interviews were conducted as part of an initial pilot study in 2018 and focused broadly on health and health care inequities. A desire to feel more connected to other transmasculine people surfaced as a salient theme in my early interviews and I turned my attention to this in subsequent interviews. Through a process of contemporaneous data collection and analysis, an additional 19 interviews were conducted and analyzed between 2019 and 2021. My analytical process included close textual readings, using initial line-by-line coding to develop focused codes, and using analytic memoing and graphs and charts to map relationships between ideas and to organize focus codes into a set of categories and properties. This iterative process meant that I could engage participants in the developing analysis. Early interviews were formative in terms of identifying the questions to ask, and interview questions were increasingly honed toward theory development as a form of theoretical sampling (Charmaz, 2014). Further, in my work with TMHJ:LA, my collaborators and I routinely discussed and grappled with concepts of community building and collective healing, and these conversations necessarily shaped how I came to these questions and analyzed the data as a researcher. I used a reflexive memo-ing process throughout the study, as described by Charmaz (2014), to surface my ideas and feelings in relation to the study as a process. The purpose was not to eliminate my own perspectives but rather to ensure that my analyses were sufficiently grounded in the data and participants' words and ideas. This was particularly relevant given my intention to

It is useful to note here that I do not explore the many other relationships in the lives of participants, nor other communities that they belonged to (e.g., faith-, artist-, or school-based communities). I did consider how participants multiple identities, and especially their racial or ethnic identities, were relevant in community building. I emphasized the perspectives and voices of Black people, Indigenous peoples, and other people of color in the analysis and in reporting the results because this was a working value of the community organizing project, and because of the limited focused on transmasculine people of color in transgender health research more broadly (Farvid et al, 2021).

Research reflexivity

A central component of a CGT research design is to acknowledge and increase the transparency of the role the researcher in the analytical process (Charmaz, 2014). Thus, to further situate myself, I joined the TMHJ:LA initiative in 2016 as a university-based collaborative research partner and doctoral student. I am also implicated in the sense that I am a transmasculine person with a background and interest in community organizing practice. I came to this study with an investment in the research questions, including my own desire to build more robust and sustainable care practices in my own relationships and community organizing efforts. Thus, while I am an “insider” in this sense (Kanuha, 2000), I was also an outsider in terms of various other forms of social difference between me and participants I interviewed. Most importantly to this study, I am a white person focused on prioritizing the perspectives, voices, and experiences of Black, Indigenous, and other people of color (BIPOC) as part of my broader participation in a community effort led primarily by transmasculine BIPOC. Other aspects of my identity important to name include that my own social networks include many trans people; I am frequently “clocked” as trans (or perceived as gender non-conforming); and I am academic conducting research with many participants who have had less access to higher education and/or varying degrees of disdain for or trauma related to educational institutions.

Results

In part one, I provide a brief overview of the social diversity of the participants including differences in their sense of connection to a "trans community." In section two, I present findings from the constructivist grounded theory analysis.

Part 1: Social diversity and connections to "trans community"

Table 1 includes a snapshot of participants (pseudonyms) with their gender, sexuality, racial, and/or ethnic identities and age range. Pseudonyms were selected by participants, and identities are reported in the table verbatim to a demographic form collected after interviews. It is worth noting that four participants whose names were conventionally feminine, and many who had gender-neutral names, as well as names that would signal ethnicity, chose typically Anglo and masculine pseudonyms for the study. Seventeen participants identified as a man or trans man, or as male (including intersex male) and some also identified with another term, while 9 exclusively identified with another term, including two-spirit, genderqueer, nonbinary (or nb), gender non-conforming, masculine of center, and ftm. Fifteen participants were BIPOC and eleven were white.

Table 1. Participant pseudonyms and identities

Pseudonyms (pronouns)	Gender, sexuality, racial/ethnic identities, age range
Ben (he)	white, gay, trans man, early 30s
Benjamin (he/she/they)	Brown, Mexican-American, queer, trans, genderqueer, mid-30s
Brody (he)	white, straight, man, transgender man, early 60s
Chen (he)	mixed Asian, grayscale asexual, non-binary FTM, early 20s
Clark (he)	Black, pansexual, trans man, early 40s
Cory (he)	white, queer, trans man, mid-30s
Damien (he)	white, asexual, man/trans man, early 30s
David (he)	Chinese, transgender man, 50s
Dree (he)	Latino, heterosexual, trans man, mid-30s
Edgar (he)	Mexican-American, heterosexual, male, late 30s
Ethan (he	white, queer, trans man (also gender is fake), early 20s
Isaac (they/he)	Indigenous, Xicanx, two-spirt, trans, early 50s
Ivan (she/they)	white, queer/bi, genderqueer, early 40s
Jacob (he)	Black, straight/heterosexual, transmale, early 40s
Jim (he)	Black, pansexual, FTM, late 20s
Kamal (they)	Black, genderqueer, early 20s
Keith (he)	Asian/Filipino, demisexual, male, late 20s
Liam (he)	white, gay, male (trans if needed), early 30s
Mahlik (he)	Black, Asian, queer, gnc, masculine of center, late 30s
Max (he)	white, gay/queer/pan/bi, transdude, trans man early 30s
Orion (he)	white, queer, male (transsexual), late 30s
Otto (he)	African-American, asexual, transman, ftm, late 20s
Renny (they/she/ze)	South Asian, pan, no gender labels or nb, late 30s
Roman (he)	white, queer-ish, trans man, early 30s
Travis (she)	Filipino, queer, gender non-conforming, mid-20s
Trystan (he)	white, queer, intersex male (with lived transmasculine experience), mid-30s

Participants came from a range of class backgrounds, variously describing their families of origin as poor, working class, middle-class, and affluent. I did not systematically collect information related to education, although four were currently university students (one undergraduate, three graduate), several mentioned attending college or university, and a few mentioned not having a degree. Five were currently unemployed, eight had full-time employment, one was retired, and others had part-time work, ran small businesses, were contingent or gig economy workers, or combinations of the above. Participants worked across a range of occupational fields including the arts, film and television, public service, education, health care, and telephone-based customer service, and some had backgrounds in cash economies (e.g., sex work, domestic labor). They lived throughout Los Angeles County (and one in Orange County) and had a range of housing situations, although most were renters and some had temporary housing situations (e.g., staying with friends). Eleven were living with partners or spouses (including cisgender and transgender women, cisgender and transgender men, and people with nonbinary genders). Four were parents and two mentioned caregiving for elders. Eight discussed chronic health problems (e.g., heart condition, chronic pain, auto-immune, psychiatric). Four mentioned alcohol and/or drug abuse recovery, and some shared that they had been systems-impacted (e.g., foster care, incarceration, voluntary and involuntary mental health-related hospitalization).

Participants' social networks ranged considerably from those who had close relationships and felt connected to multiple communities to those who were more socially isolated. Most participants had close social ties with other trans people, and especially other transmasculine people. They were roommates, friends, dates, partners, exes, "brothers," "elders," co-organizers, "most of my friends," and "part of my wider social circle." Participants spoke about knowing other trans people through their involvement in transgender-specific (or "queer," or "LGBT") organizations, social groups, and online networks. It was often more difficult for participants to answer whether they felt connected to a "trans community." While some answered emphatically "yes" (and some expanded the concept to "trans and queer community"), this was the exception. More often, "trans community" was described as ephemeral, felt at an event or in a moment, sometimes as a source of joy, sometimes as an object of longing, and sometimes linked to conflict. There was an emotional weightiness to the term, as it sometimes conjured up a sense of responsibility or uncertainty about belonging. Some contemplated why they did not feel especially connected with varying degrees of wistfulness or indifference.

Part 2: Transmasculine social care

In this section, I illustrate three core categories of "transmasculine social care," a term I use here for the ways that participants took care of and received care from other transmasculine people. Guided by CGT, I focused not on the specific forms of support, but on their meaning to participants and why they were helpful. Each section below offers a category of transmasculine social care discussed by participants and includes a descriptive account of some of its properties and factors that enabled and constrained them in practice.

"Who I am is not just for me": Epistemic work to expand what is "real" through witnessing and validating

Epistemic work refers to the production and caretaking of knowledge. This includes acts of witnessing and being witnessed and validating each other's lived experiences and embodied knowledge within and against dominant scripts of female sex assignment, hegemonic masculinity, and transnormativity (a term describing dominant notions of trans experience as a linear and medicalized "transition" from one gender to another). Participants engaged with other transmasculine people's visual images, narratives, ideas, and embodied presence as raw materials for understanding their own bodies, comprehending their "situation," and as one participant put it, becoming "grounded in who I am." Processes of witnessing did not necessarily require physical proximity, contact, or exchange; they crossed geographies, modes of communication, and even historical periods (for example, finding validation through learning about transmasculine people who lived in the past). Some participants recollected how an acquaintance, a stranger's social media profile, a character in a movie, or even hearing that a trans man "existed" or was "a thing I could be" produced a sense of profound validation, and for some, brought immediate relief. Kamal's example of witnessing a stranger's social media profile was exemplary:

> I found their Tumblr and I was like, "Oh my god, this person's me! This person has the body I've always wanted. This person identifies with what I think I want my gender to identify as. And they are, they are doing it! …They're just living their best life. I can do that. I can do that."

Kamal went on to say it was not necessarily about replicating someone's image but having language where there had previously been none. Participants tied practices of witnessing and validation to numerous benefits including reduced isolation, anxiety, and depression; self-care (e.g., loving myself, physical activity, sobriety); and more satisfying relationships. For Kamal, witnessing not only provided a language concerning the body and identity but a compass for moving toward their "best life." Benjamin (he/she/they)[2] spoke of the dramatic shift in his life after meeting a group of trans people for the first time at a research focus group. Explicit in explaining that "it was mostly people of color, working class, and poor folks from the community," Benjamin said the experience had "opened a door to community life for me" with positive implications for her personal health:

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[2] In the case of participants who used more than one gender pronoun, I use alternating pronouns throughout the text. For the reader, I include a parenthetical next to a pseudonym when referring to a participant who use multiple pronoun sets (e.g., he/she/they; they/he). No parenthetical is added for participants who used a singular pronoun set.

> To feel like even my narrow (or what I thought was my narrow) experience was a completely valid and real trans experience. That I had a right to talk about and own and to share. … It was just a drastic shift from what I had been experiencing before, which was just a lot, a lot of self-doubt and a lot of questioning and a lot of fear and anxiety. I was able to discuss a lot of those fears with people, and also just witnessing people, living their lives was important.

Validation was a keyword in the lexicon of a caring ethos in which participants witnessed others and offered their own accounts to be witnessed. This is what Kamal was talking about when they said, "who I am is not just for me," gesturing to a sense of collective responsibility to be witnessed because of experiencing the benefits of witnessing others (e.g., "I knew that I was a possibility because I saw them"). Kamal had gone on to create social media content, first sharing about experiences getting surgery but eventually branching out to discuss a range of life experiences, like conflict they were having with their mom. In this sense, witnessing pushed them toward finding alignments beyond matters of gender identity, Kamal went on:

> And then one of my friends who I'd been following online was like, "I needed to see this because I feel like I'm about to go through this with my mom." You know? … So, even if it's not even advice, being witnessed and knowing that this happens and that people are not necessarily okay afterward but there's someone who is having a similar experience that I can lean on and can witness me through it, too.

There was a sense of possibility, even urgency, to extend validation to mitigate isolation for others. This was particularly salient for some participants who were older (than age 30) or who felt they had come to understand their identity “late” in life. Jacob told me, for example, that he volunteered at a camp for LGBT youth every year, just in case there was a “little me” there. He continued: “If I had seen me as a kid, Sid, if I had seen a Black trans man as a kid, I wonder how different my life would have been. I can only imagine.” Clark had developed networks for Black trans men and other transmasculine people of color to share their narratives and build community online. Speaking to the ongoing needs for witnessing and validation for Black trans men in particular, and his own participation in these forms of caregiving, Clark provided a recent example:

> I met a trans man just recently, over the last six months, that literally said that he navigated the world by himself because he felt like he wasn’t supposed to talk about the things that he was going through. And that he felt like was alone, and he was the only trans man. This is in LA! He felt like he was the only trans man in his area, that no one else understood him. And literally, I went out, I went out to meet him and he cried in my arms. He was like, “I can’t believe that there’s another person that looks like me and understands what I am going through and that there’s a whole family waiting for me on the other end.”

Being witnessed and validated were not only then about the cultivation of an individual future self, but a future self in community, a “whole family.” I thought about Clark’s use of “the other end,” and the “path toward each other,” as a gentle interruption in the dominant narrative of an individual trans “journey” through gender transition. Here, the other end requires and produces epistemic caring and builds community.

As many discussed, being witnessed can be transformative and exhausting—and there are risks involved. Cory made this point in self-reflexively acknowledging some of his reticence in looking for connections with other transmasculine people since moving to Los Angeles. Although he had been connected before, he said it was not as much of a priority for him now:

> I have some, like, self-hatred around being trans. I mean, I have some self-hatred about, like a lot of things. [LAUGHS] … But I feel like when I see something like a “trans support group” pop up, it's like, ‘I don't need that. I'm not trans.’… Most people looking at me don't realize that I'm trans unless they're also on the queer spectrum somewhere and, you know, it can be really nice to just hide and not have to acknowledge this part that feels really vulnerable. ..... Honestly, it feels like talking about being trans is inviting people to think about my body and that feels really scary.”

Thus, as witnessing and validating were practices of care, there were constraints and uneven effects across various forms of social privileges, including whether there was a choice over when and how to be witnessed.

Participants also spoke about first impressions, dominant representations, and subcultural communities that were unrelatable or raised their anxieties about personal safety. The dominant role of medicine in framing “trans communities” limited access to validation, and a sense of belonging. The three participants who did not identify as men and did not currently use testosterone described feeling in a “middle space” that was lonely despite otherwise being connected to queer (but largely not transgender) communities. Travis spoke self-reflexively of her own pattern of witnessing and looking for validation:

> You can see the little bouts of my identity crises if a lot of FTM folks pop up on my "discover Instagram" page. It shows that I was really, like, going through it. Then, sometimes, I'll be scared looking at the surgical stuff, and, all the changes, and then, I'll stop looking at it because it just gets overwhelming.

Travis said she was unsure if she should use the word "trans" for someone in her "situation," explicitly describing being comfortable with she/her pronouns and using women's bathrooms. Relatedly, Orion, who had started taking testosterone in his early 20s, began to use the term transsexual man to describe his experience because he did not feel connected to a perceived cultural and generation shift toward concepts of trans people as more gender fluid. On the other hand, Mahlik, also in their late 30s, recalled that the first time they felt witnessed and validated in their identity was when they met younger people at a queer community organization.

> [They] asked, "Oh, what's your gender pronoun?" No one had ever asked me that before ever. And, I was like, uh… "he" and, you know, that felt good because it never felt good to be "she'd." I didn't know people saw something in me. I didn't realize but people looked at me as gender non-conforming already and as, like, trans. They were already treating me as such, and I wasn't even there yet…. It was interesting to finally find a community where I'm like, "this feels great" … that was my real big introduction.

Mahlik's experience points to how witnessing and validation are cultivated and crafted at the level of the collective. (And notably, asking someone about their pronouns is perhaps one of the most tangible examples of how a trans epistemic work has imprinted broader culture.)

"Find your brothers": Healing work through externalizing oppression and nurturing transmasculine intimacy

Healing work refers to processes of social care that involve recognizing patterns and consequences of oppression and developing ways to intervene or look out for each other. Participants drew on their personal experiences, friends' experiences, social media engagement, and involvement in advocacy and activism as they identified specific (racialized[3]) transmasculine social care needs. They spoke, for example, about risks of isolation, conflict with or rejection of parents or family members, disconnection from cultural communities, negative self-image, difficulty setting boundaries, self-sabotage, losing friends, income instability, institutional discrimination, lack of access to health care, challenges in seeing an adult self, and exposures to violence and abuse (e.g., parental, intimate partner, dating violence, childhood sexual abuse). Participants recognized that these were problems that many non-transmasculine people also face, but often interpreted and linked their own experiences to patterns and needs specific to a trans(masculine) experience. Some directly referenced "the statistics" (speaking most saliently about suicide, but also sexual violence). Dree applied this language to himself as he reflected on what had felt inexplicably tied to a transmasculine experience in his own path toward self-harm, addiction, and suicide:

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[3] I use parentheticals here to denote that it was explicit for some participants, and especially Black participants, that transmasculine experiences are inextricably bound to racialized experiences and were therefore central to the community building process.

> I went to great schools. I grew up in [an affluent area]. That's my story. I honestly don't remember any traumatic experiences as a child…. I was a good happy kid until I hit puberty. … I just started cutting myself, and nobody knew what was wrong ‘cause it was good, by all accounts. There are probably a lot of people who would have died for the life that I grew up in. But that path, suicide—I have eleven 5150s from legit suicides—cutting, alcohol, addiction, jail, homelessness, I absolutely fell into the statistics of the transgender community.

Knowing about, and feeling a part of “the statistics,” offered language to frame and make sense of past experiences, mitigating feelings of shame (or internalized oppression), and provided the emotional shelter of shared experience, or the feeling of being “among many.” Interpretations of past experiences that felt specific to transmasculinity underlined beliefs and motivations of participants’ engagement in healing work. Participants, including Dree, explained having been refused or mistreated in formal care services—for example, being required to present as a woman to access in-patient drug treatment programs or being turned away from men’s support groups for sexual violence survivors. Dree had since dedicated his life to drug and alcohol treatment counseling, specializing his work in helping trans people in recovery. Several other participants had started organizations or been long-term volunteers, and some had built careers around addressing the care needs of trans people.

In paying attention to risks or “what’s going on” for transmasculine people, statistics cut both ways. Those who engaged in advocacy work described feeling absent, even silenced, through numbers. Jim, for example, spoke of how failing to include suicide deaths during the national Trans Day of Remembrance (an annual vigil for trans people lost to lethal violence) "contributes to the idea that transmasculine people don't go through anything, and it's not a state of emergency for us." This sense of urgency, combined with a feeling that "no one else is talking about it," as Clark put it, moved participants to engage in the care work of looking out for the social needs and survival of other transmasculine people. Clark continued:

> We have so many trans men that are dying of suicide because there's no mental health resources available to them. They don't have anywhere to go and say, "I'm not okay." Because there's all of this stigma around the masculinity piece that says, "We don't have feelings. We don't need to speak up about our feelings."

Here we see how healing involved work attention to an interplay of gender oppression, including gender binarism, gender "socialization" (as assigned girls) and for most, past lived experiences as "female-presenting people," and the pressures of hegemonic masculinity. These specificities of gender oppression do not easily comport to existing frameworks. However, exclusion from existing discourses of gender oppression were the conditions for transmasculine healing work, as a motivation to seek each other out. For instance, Kamal described "finding community" in a workshop at a national gathering wherein the facilitators guided the group through exercises designed to disrupt the impacts of systemic oppression on both individuals and community relations. Kamal came back from the experience with new friends and kinships, recalling:

> It was a space of beautiful masculine-of-center folks of color, and us acknowledging each other, being tender with each other, and telling each other that we were attractive, or

> attracted to each other, or acknowledging that we look damn good, and we want to be soft with each other.

This experience stuck with Kamal because it was transformational for them, but also because it was so exceptional. When Kamal went back to share some of their experiences with the LGBT group at their college, they said they were shamed for talking about being attracted to other masculine people. Other participants also acknowledged the intracommunity work required to overcome hardened patterns of self-protection. For example, Clark had met the man who cried in his arms through an online community that he created for transmasculine people of color. When I asked Clark why he started the group, he drew connections between acts of paying attention to statistics and paying attention to people:

> I'll go in and moderate and say, "Hey, check in! I need to know how everybody's doing." You know, "is there anybody in need of a hug? Anybody in need of a donation? Anybody need a conversation? Does somebody need a 'reach out'? Or, do you have an accomplishment that we can celebrate you for?" That way, at least, they're uplifted and they know they can reach out and say, "No, I'm not feeling okay."

Participants self-fashioned, experimented with, benefited from, and desired more spaces for sharing feelings and developing emotional intimacies. Roman self-organized a space for "masculine-identified" people in his social networks (both transmasculine and cisgender men) to talk about masculinity, boundaries, and conflict. The group was new, but he said that members took turns facilitating the meetings to learn from one another. Speaking to emotional intimacy specifically, he said he hoped the group would be an opportunity to support each other and “to kind of press into the things that we resist… [so that] we can be present and have boundaries and have conflict experiences, so they don’t feel like conflict in the same way.” Jacob created an informal gathering space at his home, focusing on reaching Black men and other men of color who are stealth (few people know them to be trans). He told me one of the crucial aspects of the group was that it was informal, “kickback to hang out.” But there was a deeper theory of practice tied to the development of emotional intimacy:

> I'm like, “there's nine slots available. I've invited 30 guys, the first nine to get back to me, that's who's coming.” It's to keep it intimate, to keep it intimate, so that people start to meet new people. What happens is that the same people end up starting to come all the time, are signing up, and others fall off. Then, after a while, you have an intimate close group of guys and they end up making friendships that last forever.

This is what Jacob was talking about when he told me “I think it’s just really, really important to find your brothers,” speaking to the key role friendships play in healing work.

As Jacob’s strategy suggests, many participants voiced that they found formally organized support groups and/or spaces organized exclusively around trans identity as important for externalizing oppression, but limited in terms of nurturing emotional intimacies over time. Some assumed or experienced identity-based support groups as focused on the needs of people “starting out” (in reference to gender transition) and focused on medical interventions. The limitations of existing social supports were also brought up with respect to needs around healing from traumas and especially intimate partner and sexual violence. Many participants looked for emotional aid from other transmasculine people in relation to violence but did not know how to cultivate it in an organized group setting. Max told me he had recently attended a trans support group after a sexual assault but was uncomfortable discussing it out of concern that doing so might trigger or upset other participants. David, who had been involved with several trans advocacy projects, connected his sense of feeling alienated from a "trans community" to a lack of space to talk about his life history of domestic violence. In an emotional moment of considering his lack of connections, he said:

> I have kind of sat here and thought, you know, why do I not feel that with my own community? I think that's just the thing, in the community that I work with. … I feel this tightening right now in my chest, and it's like, I think they don't really know fully what my life has been like. … it's difficult for me to build trust.

Taking on an advocacy role had brought David into contact with other transmasculine people, but he felt it was also a barrier for asking for help or developing more emotional intimacies. He said he withheld some of his own social and health care needs because he didn't want to be "a burden on my own community when I am supposed to be the one helping them." Isaac spoke about responding to this problem, telling me that "one-on-ones" was a core community building philosophy for them. Recognizing a pattern of people disappearing from advocacy work when they were not doing well, they told me: "I am very conscious. I'll send letters, like snail mail. I'll send text messages. …. It's just to know that somebody is thinking about you."

Participants emphasized emotional work in supporting their transmasculine friends to pursue career goals, access health care, and even interrupting negative thought patterns. Damien, an emerging comedian, highlighted the expertise he has developed through supporting his closest friend: “Part of me thinks I should have like a PhD in therapy or at least a PhC in therapy, just for the amount of times I've told [my friend], ‘Look, people are not normally mean. They don't normally hate you.’” Damien said he recognized his friend’s pattern of thinking in himself and as a common response to early childhood trauma, demonstrating social care work involved in fortifying friends against the effects of internalized oppression.

Discussions of healing work also included conversations about material care needs and care. Participants worked to externalize having “financial problems,” chronic unemployment, and housing and food insecurity as related to a transmasculine experience (e.g., “many people in the community struggle with this”). A sense of a shared economic context meant healing work was also materials, participants routinely discussed forms of support tied to meeting basic material needs. No one I interviewed was formally involved in mutual aid strategies, but nearly all participants had exchanged forms of material aid among trans friends, including food, places to stay, covering rent, gas money, and “passing the same $20 around.” Some mentioned contributing to crowd-funding campaigns for emergency needs, giving and receiving advice about “life hacks” (e.g. how to get a free bus pass), and support and accompaniment in accessing healthcare services and social welfare programs (e.g., unemployment, food banks, Medicaid).

“Let me do my part”: Accountability work through sharing information, taking action, and solidarity

Accountability work refers to forms of social care that involved feeling a responsibility to align with and act to benefit trans people as a social class. Accountable care was implicit in the first two categories; that is, acts of epistemic and healing work were motivated in part by a sense of accountability. Yet, accountability is a distinct ethos rooted in a sense of linked fates. This was especially apparent in participants' contributions to knowledge projects (including this research project), advocacy work, and social activism. It was reflected in the ways participants described their relationships or connections to other trans people through a vocabulary of investment in and obligations to an abstract "trans community."

Sharing often personal information in public forums in hopes other transmasculine people will benefit is quintessential accountability work. This was especially discussed in relation to gender-affirming surgeries, hormones, and clinical care. Some participants, like Kamal, shared personal experiences online, and others spoke about sharing information in support groups settings, including surgical experiences, accessing resources, navigating institutions, relationships, sex and sexuality. The large, dispersed online networks of trans health knowledge are examined in some depth in other scholarly accounts (e.g. Pearce, 2018) and thus, I point to them here briefly (although there were many examples) as exemplary of processes motivated by a sense of interdependence. Participants in this study contributed to and benefited from these forms of knowledge exchange and relied on this information to improve their quality of life and to craft their health care plans. Participants built communities with other transmasculine people via these health knowledge information networks. In one example, Brody told me that he had started a private Facebook group for people interested in undergoing phalloplasty with a local surgeon, and the group now had well over one hundred members. Brody said the group offered a place to trade information and seek advice about the surgery, but it was also a way to build relationships. For example, when I asked about group membership, Brody told me I should join and followed up saying: "When I meet somebody who's transgender-identified, female-to- male, I say, 'Hey, do you want to get invited to this group?'" Networks centered around trading health care information were sometimes the primary or only sites participants referenced when they talked about connections to a trans community. For a few, they had been portals to other forms of community building, including advocacy efforts and social activism.

Accountability work was reflected in the ways participants engaged in work to change conditions for other trans people through advocacy efforts and social activism. About half of the participants in this study had been deeply involved in trans community organizations, including as founders, leaders, and/or long-time volunteers. Those with less experience with trans community organizations were also comparatively less connected to a distinctly "trans" identity, including people who identified primarily as men and those with nonbinary genders. Those who were more involved in identity-based or social movement organizing tended to speak of benefits in terms of friendships, social connection, self-confidence, knowledge, professionalized status, and even a sense of life purpose. At the same time, many spoke of health costs involved with assuming the responsibility and pressures of advocacy. Participants described staring down an overwhelming sense of social need and crisis, or as Max summarized it, "a lot of things that are very upsetting." Feeling responsible to act on multiple fronts with few resources was a source of stress, and participants spoke reflexively about the confluence of social responsibility, resource scarcity, and fatigue. Noticing fatigue, however, was also emblematic of an accountability ethos. Jim recognized he had adopted habits that he felt was common for care workers, but were antithetical to his values:

> I had no boundaries… I was just taking all of it in, and I got sick, physically sick. And I was like, "I still gotta do this for the people. The people, they need me." I was sort of embodying—what is it called—the martyr-nurturer complex, where you start to resent people that you're helping, because they're not grateful in the ways that you want, and not

> taking help in ways that you want. And it becomes a way to avoid dealing with your own shit, ‘cause you're so focused on helping other people.

Although Jim recognized the toll that his advocacy work was having on his well-being, he did not question whether to continue. Rather, he framed his feeling of burnout in terms of a desire to become a better care worker. Accountability work, in this sense, was defined by reflexivity about one’s position, skills, and capacity.

Some participants, and particularly those involved in advocacy and activism, tied intergenerational relations to their sense of accountability. Jim said it was an “elder” who first encouraged him to notice that not only was his own health suffering but also his ability to genuinely care for others. This was also one of the primary examples Jim gave of care he had received from a group of mostly Black trans and nonbinary elders, telling me:

> I don't trust every elder but specifically people who have clear boundaries and have been able to stay doing community work for a long time in a way that recognizes that burnout happens but they have ways to sort of replenish themselves to stay committed in the work.

Still in his late 20s, Jim had already been called an “elder” by people in his social circle because of his advocacy work. A language of gratitude, it was also, in Jim’s opinion, undue given his age and his own desires for personal growth. Being an elder was an obligation and a responsibility, which was something that Isaac situated specifically in an Indigenous context. When I asked about their sense of the word “community,” they responded:

> In my age now, I'm able to support young folks. I'm kind of in that middle phase. A young elder. … I was calling for my ancestors to support me in finding a community that I was really desperately looking for. I think once I started to take on that role, and the responsibility of that role as well, with other Native two-spirit folks … it was a place for me to really connect with other two-spirit people in particular, and two-spirit elders, which is – you know, I did not know any two-spirit elders and now I have a good amount.

For both Isaac and Jim, taking on a social care role and working to develop an accountable practice had the effect of building deeper trust and community ties, which in turn contributed to their sense of social health and well-being.

In another register, accountability work could be observed in the ways participants felt compelled to grapple with and cultivate solidarity across social differences among trans people. Participants who were unsure about or did not use the term trans for themselves tended to speak of their uncertainty in the language of accountability. For example, Ivan, Renny, and Travis expressed caution about “assuming” or “taking” a label for an experience that they were not confident they should claim. Trystan, on the other hand, worked to traverse a divide in understandings between intersex and trans experiences and to render trans a more expansive discursive space:

> I always feel a little bit awkward though. I kind of say, “I'm intersex, but I've experienced some of these [trans–] things,” because we don't quite fit in anywhere. We're not cis, but we're not trans, but do we just make our own group? So, I just kind of pushed myself in

> and I'm like, I'm going to talk about things that I do know, and just don't tell me that I'm not allowed to because you don't know what I've experienced.

Here, Trystan engaged in a different dimension of accountability work as he looked to hold a “trans community” to task to reckon with and include his intersex experience. Several participants engaged in a kind of self-reflection when I asked about their connections to a “trans community,” some interrogating their internal belief systems, perceptions, and biases that they felt might be exclusionary. Accountability work, in this case, involved a commitment to self-education and challenging biases. This was especially discussed by trans men in terms of building community with people with nonbinary gender identities. Dree said he had felt judgmental at first when he met people with non-binary or fluid gender identities. He told me: “I was being the very thing that I hated, and so, by exposing myself more, and learning more about the individuals and hearing these stories … [it] allowed me to soften my heart.”

Even those who were ambivalent about their “place” in “a trans community” nevertheless felt implicated in its social and political development. Orion, for example, felt he had been ostracized in Los Angeles queer and trans communities for being perceived as “a straight bro.” While he had found a greater sense of belonging in gay men’s communities, he still sought out and participated in this study to ensure experiences like his are “represented or counted properly.” Concerns about representation and inclusion led to a range of different strategies for social care. Jacob, who said he felt like a misfit in trans communities (e.g., “I'm binary. I'm heteronormative. I'm super old school”; “I feel that I'm biting my tongue, that I'm walking on eggshells”), also underscored his love for these same communities:

> I would give all my blood, sweat and tears to make sure that I leave something or build something to support this community. … I love trans people. I think trans people are freaking beautiful, amazing butterfly, divine creatures, and whether or not I feel like I fit in the spaces, it's kind of irrelevant. What I do know is, that community is being built. .... I think that trans people are doing great work. I just think that there's so much work to do that it can be done in so many different angles. There's so much to do. So, let me do my part, you know.

Speaking to the power of accountability as a social care ethos, both Jacob and Orion felt called to "do their part" in producing knowledge about and transforming social conditions for trans communities despite a sense of rejection from these same communities.

Discussion

This study identifies *transmasculine social care work* as including the epistemic work of crafting and validating counter-narratives, the healing work of resisting oppression and cultivating emotional intimacies, and the accountability work of sharing information and coalition building. By doing so, this study does two central things. First, focusing on how building community is *work* more firmly locates the link between community connectedness and health in political terms (Collins, 2010)) This not only supports more capacious readings of trans communities (as multiple, coalitional, negotiated), but situating the benefits transmasculine social care workers aim to produce more squarely within an analyze of "economies of abandonment" (Povinelli, 2011).

Doing this raises important questions for social scientists interested in measuring and testing the social and health benefits of being connected to transgender communities. Findings that participants felt uncertain about belonging to, and even alienated from a "trans community" despite participating with a sense of social and political interdependence, are nuances unaccounted for in common measures (e.g., Sherman et al., 2020; Testa et al., 2015). More to the point, the rationale for hypothetically testing the benefits of trans community connectedness is deserving greater review. If intended to offset pathologizing discourses (or to illustrate something positive about being trans), the implications of these studies may have an opposite effect, shifting pathologies from individuals to communities. For example, when results show that certain trans people or groups do not benefit from being connected to trans communities, or that trans community connections are insufficient to mitigate stressful social conditions (Breslow et al., 2015; Valente, 2000), researchers may unwittingly train implications toward the problems or insufficiencies of trans social care, rather than toward the unrelenting conditions of crisis, political opposition, structural racism, and resource scarcity facing trans social care workers.

More attention and care are warranted in a time in which trans communities are under political attack and trans communities are marked as dangerous (Ashley, 2020). This is not to say that studying the health promoting effects of being connected to a transgender community is not a worthy endeavor. The present study and a growing body of research help describe why and how being connected to a transgender community might matter in terms of health and well-being (e.g., Johnson & Rogers, 2018; Shuster & Westbrook, 2022; Singh, 2011). Community organizers may seek to evaluate specific programs or campaigns to understand their reach and whether they are meeting the needs of participants. However, when tested in more generic terms, and without the context of the labor involved, findings that transgender community connections fail to promote health may unwittingly comport to opposition narratives, while positive findings risk further entrenching the status quo in the register of self-care.

Next, and within the thorny terrain in which care labor is displaced onto minoritized communities, identifying transmasculine social care can contribute to its development. By looking to the “community's creation of ‘communities’” (Bailey, 2009, p. 272), we see not only the labor, or “blood, sweat, and tears” of building communities but can examine ethos of care as knowledge building in attendance to emergent needs. Following Bailey (2009), focusing on strategies in practice help differentiate imposed interventions from cultural *intra*vention, and the relationships between them. In Bailey’s reading of Detroit’s Ballroom scene *as* HIV intravention, a public health discourse of “populations at-risk” is juxtaposed against a Black queer ethos of “lives worth saving.” Participants in this study challenged the public health framing of transmasculine people as “low risk” and “hard to reach” through cultural intraventions based in an ethos of recognizing risks and finding each other.

Transmasculine participants engaged in this health care work largely informally, in their relationships and through social networks. More BIPOC participants spoke of organized strategies, which some had parlayed into formal roles with organizations or incorporated their own projects. Another study might use a participatory approach to identify opportunities to grow and sustain these forms of social care work consistent with local needs. Collective knowledge production practices, like TMHJ:LA, can bring otherwise socially distant transmasculine people together to explore and share strategies (e.g., participatory action research, cultural performance) and further develop healing work already in practice (Perez et al., 2021). Efforts to expand social care provisioning through organizational formations such as those Greene (2021) names as “transgender kinship organizations,” may provide infrastructure to deepen this work and meet more immediate material needs. Incorporation, however, can create administrative burdens, invite forms of surveillance, and risk emulating power hierarchies of social service environments

(INCITE!, 2007). Thus, as Greene (2021) contends, this is “less of a panacea than an invitation for ongoing reflection, evaluation, and experimentation” (p. 944). Expanding the influence of epistemic work through narratives that extricate gender meanings from legal and medical overdetermination and resist imperial investments in consolidating a “transgender community” while strengthening coalitional possibilities, are but some of the implications for an emergent transmasculine social care practice.

The kinds of social care explored in this study predate the recent wave of organized mutual aid efforts during the height of the coronavirus pandemic, and no participants discussed mutual aid explicitly. Rather, identifies transmasculine social care work as “transgender health care” as part of a broader effort to rework dominant meanings in alignment with much needed holistic models of care that address health inequities. This provisional exploration of social care as health work, might build on and extend understandings of coalitional and accountability politics within Black feminist ethics of caring (Collins, 2002), and related cross-generational solidarity organizing of among Black trans women (Lundy-Harris, 2022), and intersecting racial justice and disability justice community organizing (Piepzna-Samarasinha, 2018).

Conclusion

In a time when transmasculine people are experiencing daunting mental health inequities, and trans communities are under direct political attack, participants in this study desired and worked to cultivate care practices by and for transmasculine people. As researchers increasingly look to study the ameliorate benefits of “trans community,” more attention warranted to the social and political conditions in which community building becomes necessary and urgent, but also to the theories of care and their transformative influence. For example, epistemic caring practices elaborated in this study might account for a growing number of young people who are embracing gender diversity and cultural shifts toward more gender-inclusive language and practices. Articulating a distinctly transmasculine social care offers needed nuance to theories of gendered care, which tend to elide the specificities of being assigned female by equating gender with women and/or femmes. Illuminating processes of paying attention to the effects of racially specific gender oppression in the development emotional intimacies among masculine people, and efforts to challenge hegemonic masculinity (while also contributing to broader social justice efforts for trans people) also reveals this transmasculine social care ethos as a transfeminist practice. Future research might expand here, including analyzing other kinds of transmasculine care work (e.g., material, domestic, emotional) and the extent to which these may account for diminished recognition, participation in, and access to tangible “transgender community” resources.

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Chapter 4: Specializing care: Transgender-specific services as health equity promotion

Abstract

In response to healthcare inequities for transgender people, community organizations in California advocated for public funding for dedicated sites of care. This study examines this structural change intervention by analyzing the utilization and benefits of having a transgender-specific healthcare provider (THP) as a primary care provider among a community sample of racially and ethnically diverse transmasculine adults in Los Angeles County (n=300). A theoretically driven structural equation model was developed to test the effects of having a THP on participants' responses to the 9-item Patient Health Questionnaire (PHQ-9), a validated measure of depression severity. The final model had good fit (TLI = .95, CFI = .97, RMSEA = .039) and explained 35% of the variance in PHQ-9 scores. A relationship between THPs and reduced depression was explained by the effect of greater access to trusted care providers, fewer exposures to adverse interactions in healthcare settings, and reduced barriers to care. Although THPs were associated with utilizing gender-affirming healthcare (e.g., hormones, surgery), the health benefits of THPs were not reducible to access to these interventions. Income had a direct health benefit that was unexplained by reduced barriers or quality of care. Transgender-specific healthcare services and guaranteed income programs are discussed as actionable pathways for health equity promotion.

Introduction

In September 2020, amidst a growing health crisis precipitated by the global COVID-19 pandemic, a coalition of transgender, gender nonconforming, and intersex (TGI)-led organizations in California worked to successfully pass Assembly Bill 2218 establishing the Transgender Wellness and Equity Fund. Dubbed by advocates as a "historic trans health bill," the policy's preamble states an intention to fund partnerships between TGI-led community organizations and "hospitals, health care clinics, and other medical providers to provide TGI-focused health care" (California Legislative Information, 2020). California Assemblymember Miguel Santiago told the press that the fund could help ensure that "TGI-identified people can receive safe, competent, and inclusive health care and social services" (TransLatin@ Coalition, 2020). Following the appropriation of thirteen million dollars in initial funding in 2021, advocates called the effort a "community vision becoming a reality" (TransLatin@ Coalition, 2021).

Transgender health care is a rapidly growing clinical specialty. Academic medical centers, community organizations, and public and private health care providers across the United States have developed specialized care teams and opened clinics under the banner of "transgender health" care (Gaither, et al., 2022; Jones et al., 2020; Morenz et al., 2020; Reisner et al., 2016b). At the same time, the scope of what constitutes "transgender health" care is also expanding. Often associated with gender-affirming healthcare interventions (e.g., hormone therapies, surgical care), specialized providers and clinics often work to meet an array of needs for a patient population that is largely marginalized in mainstream healthcare service settings (Ding et al., 2021; Nowaskie et al. 2019; Reisner et al., 2015a; Reisner et al., 2016b; Transgender Law Center, 2008). Community-based health organizations focused on serving women, publicly insured patients, and lesbian, gay, bisexual, and transgender (LGBT) people have used the term "transgender health care" to variously signal that they provide gender-affirming hormones therapies, but also an intention to offer affirming environments for trans people in existing services (Jones et al., 2020; Martos et al., 2017). Venture capitalist investors have speculated on the growing and unmet demand for gender-affirming medicine by selling high-cost membership-based hormone management and home delivery services, increasing access to these forms of care for those who can afford them while simultaneously narrowing definitions of "transgender health care" to its most profitable edges (Geffen & Howard, 2021).

The development and diversification of a transgender healthcare services sector parallels growth in the sheer numbers and proportion of people who identify as trans in general and in healthcare settings. By one recent estimate, the portion of privately insured patients in the U.S. with a "gender dysphoria" diagnosis (a typical requirement for coverage of gender-affirming healthcare) increased by nearly 700% between 2013 and 2019 alone (Das & Dusetzina, 2022). An analysis of patient health records in the Kaiser Permanente Health System in Southern California found a nearly 9-fold increase in the number of trans and non-binary identified patients between 2006 and 2014, with the largest proportional increases among young people ages 18 to 25 and those on the transmasculine spectrum (assigned female at birth) (Zhang et al., 2021). These demographic shifts comport with observations in general population studies (Herman et al., 2022), in pediatric settings (Handler et al., 2019), and among gender-affirming surgical patients (Lane et al., 2018), suggesting that transmasculine young people are an especially fast-growing patient population.

This study focuses on the role of transgender-specific healthcare providers (THPs) as a structural health equity promotion strategy. The origin and design of this study align with the growing calls from trans health scholars to ensure that research related to transgender health is directed by trans people and focused on the priorities of local communities (Everhardt et al, 2022; Schiem et al., 2019). The study draws on survey data collected through a community research initiative convened by Gender Justice Los Angeles, a grassroots organization led by two-spirit, gender non-conforming, and trans Black people, Indigenous peoples, and People of Color (BIPOC).[9] The initiative was designed to address the dearth of local public health data and resources for transmasculine people using a participatory research and organizing process (Perez et al., 2021). Transmasculine people have been historically deprioritized in publicly funded health research (Coulter et al., 2014) and transmasculine BIPOC are especially underrepresented (Farvid et al., 2021). Using this novel data set, and examining a community-supported structural health intervention, the specific aims of the study were to: 1) compare demographic differences in access to transgender-specific healthcare providers (THPs) within a geographically bounded and racially and ethnically diverse sample of transmasculine adults in Los Angeles County, California prior to the implementation of AB2218; and 2) to test the effects of having a THPs on health outcomes using a theoretically driven health equity promotion model.

A focus on transmasculine mental health.

In 2021, Gender Justice Los Angeles launched a report titled Transmasculine Health Justice highlighting mental health as a top concern and priority (Perez et al., 2021). The report referenced findings from the TSHRJ:LA survey (n=310) in which 39% of transmasculine

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[9] The term *transmasculine* was used by organizers strategically in efforts to include trans men and men of trans experiences, and people with nonbinary identities, two-spirit Indigenous people, and others who were assigned female at birth but do not identify as women. The term *Black people, Indigenous peoples, and People of Color* (BIPOC) is used throughout this paper for consistency with its use in the community initiative as a political category of solidarity among those targeted by racism.

participants (and 56% of participants ages 18-24 years old) reported symptoms of moderate to severe depression on the nine-item Patient Health Questionnaire (PHQ-9), a previously validated indicator of depression severity (Kroenke & Spitzer, 2002). For comparison, estimates of moderate to severe depression in the general U.S. population using the same measure tend to range from about 5.5-7% (Kocalevent et al., 2013; Shim et al., 2011). The findings echoed previous studies also showing a high prevalence of stress-related anxiety and suicidality among transmasculine people (Marshall et al., 2016; Millet et al., 2018). This includes national data suggesting that nearly half of trans men attempt suicide at least once in their lifetime (James et al, 2016; Toomey et al, 2018), a figure that grossly exceeds the estimated 1% of the general U.S. population (Olfson et al., 2107). Community organizers framed mental health inequities as a health justice issue and the result of social inequities caused by intersecting forms of oppression, (Perez et al., 2021), an analysis that is broadly consistent with a growing scholarly literature on transgender health inequities (e.g., Hughto et al., 2015; Reisner et al., 2016a; Valentine & Shipherd, 2018; Wesp et al., 2019).

Marginalization in healthcare services and delayed care.

Trans people lack access to consistently safe, relevant, and high-quality healthcare services across multiple fields of practice (Heng et al. 2018; Kcomt, 2018; Lerner & Robles, 2017; Sbragia et al., 2020; Snow et al., 2019). Medical research and services are principally organized by cisnormativity, the social fiction that people are easily divisible as men or women based on their sex assignment at birth (Bauer et al, 2009; Namaste, 2000;). Service provision takes shape through cisnormativity within a charged sociopolitical climate in which anti-trans attitudes are pervasive and healthcare rights for trans people are publicly debated (Ashley &

Domínguez, 2021). It is not uncommon for trans people to encounter healthcare workers who harbor transphobic beliefs (Stroumsa et al., 2019b) and experience direct and implicit forms of discrimination (Kcomt, 2019). Even when providers strive to meet their professional obligations, a lack of research and preparation contributes to misunderstandings, misdiagnoses, and mistreatment (Knutson et al, 2016; Stroumsa et al, 2019a). Trans patients frequently report having to assume the role of educator and advocate in clinical settings to protect themselves and ensure adequate care (Lerner & Robles, 2017; Seelman & Poteat, 2020). Yet, in the imbalanced provider-patient power relationship, providers may react by imposing stigmatizing beliefs to maintain a sense of professional authority (Poteat et al., 2013). Such dynamics can poison an already fragile and tenuous patient relationship with medical systems, contributing to broadly documented patterns of healthcare disengagement and delayed care (Hughto et al., 2018; Kcomt, 2020).

Trans men are especially likely to report negative experiences in healthcare settings and to delay seeking health care due to concerns of gender-related mistreatment. For example, in responses to the 2015 United States Trans Survey (USTS), 42% of trans men reported having a negative experience with a provider related to being trans in the past year compared to 36% of trans women (James et al., 2016), and trans men were nearly twice as likely as trans women to say that they have postponed needed health care for fear of gender-related mistreatment (Kcomt et al, 2020). Although these gender differences are not well understood, one potential factor is that transmasculine people have been underserved in community-based LGBT health organizations due to their historic and ongoing funding for HIV prevention and treatment and focus on people assigned male at birth (Martos, 2019).

Researchers have tended to ask trans people about “gender-related” forms of discrimination in healthcare or “gender-related” reasons for delaying care, however marginalization in healthcare services is complex often making it difficult to discern or disentangle forms of mistreatment that occur at the intersection of multiple forms of oppression (Collins & Bilge, 2020). For example, Black trans people especially report experiencing a confluence of racism, misogyny, and transphobia in their healthcare experiences (Hudson, 2018; Agénor, 2022). Limited research has focused on factors that influence access to healthcare for transmasculine BIPOC (Farvid et al, 2021), trans men (vs. trans women and gender non-conforming people) and trans people of color (vs. trans white people) are especially likely to live in poverty (Badgett et al., 2019; Fredriksen-Goldsen et al., 2022) and to delay care due to costs (James et al., 2016; Kcomt, 2021).

Trans-specific healthcare providers as a structural health equity intervention.

Researchers have tied direct experiences of mistreatment in healthcare settings to delayed care and health inequities, including higher rates of depression (Reisner et al., 2015b). Researchers have begun to explore the potential advantages of having an “inclusive” or “affirming” provider. For example, Kattari and colleagues (2020) found that participants in the 2015 USTS who had been “treated with respect” by a healthcare provider were less likely to have experienced suicidality or depression in the past year when compared to participants who had not been treated with respect. Clark and colleagues (2017) found that young trans Canadians who had spoken openly about their gender identity with a doctor indicated better self-rated general and mental health. Seelman and colleagues (2017a) found that among trans adults in Colorado, those with an inclusive healthcare provider had lower rates of depression, a relationship that became statistically non-significant when accounting for the mediating effects of delayed care. The findings suggested that the mental health benefits of an inclusive or affirming care provider may be explained by reduced delays (or fewer barriers) in seeking services.

Researchers have tended to focus on the quality of interactions with healthcare providers rather than on provider specialization or the site of care (Koehler et al., 2021). While it is noted that gender-affirming approaches to care can and should be available and integrated into general primary healthcare settings (Wylie et al., 2016), finding an affirming or inclusive healthcare provider can be an elusive task. Dedicated transgender healthcare services are readily identifiable sites where providers focus their practice on working with trans people and where trans patients are anticipated and welcomed. Demands for public funding for healthcare services that are directly accountable to TGI people is institution-building strategy that builds on a longer history of grassroots antiracist, feminist, and LGB health activisms (Morgen, 2002; Nelson, 2011; Martos et al., 2017; Fernández, 2019). Model transgender health clinics have demonstrated their potential to incubate expertise and novel approaches to practice, including community and patient engagement (Ding et al., 2021; Nowaskie et al. 2019; Reisner et al., 2015a).

At the same time, transgender-specific healthcare services are embedded in, and not immune to, the broader social, racial, and economic inequities that structure U.S. healthcare systems more broadly. Any potential benefits of these models require reckoning with the questions of who is (and is not) being cared for, particularly given the historical legacy of racist, classed, and ableist exclusions on which contemporary practices were developed and modeled (Gill-Peterson, 2018; Malatino, 2019; Spade, 2003). For this reason, this study aims to offer a few important key conceptual distinctions. The first is delineating access to a THPs (as a resource) from the quality of healthcare encounters to better account for the reality that patients may have negative, neutral, and positive interactions with THPs. The second is accounting for greater complexity in assessing barriers to care by asking participants about factors that intersect with trans experience, but may not be directly "gender-related," such as mental health-related stigma, economic- and disability-related barriers, and medical racism and mistrust. Additionally, the analyses takes into consideration that trans people may not desire gender-affirming healthcare interventions but may still desire and benefit from having THPs. Several recent studies establish a positive association between GAH and mental health for trans people, including lower rates of depression (Alamazon et al., 2021, Tomita et al., 2019), but few delineate the potential confounding role of having a trusted healthcare provider. This study uses a measure that focuses on access to desired GAH to better ascertain whether the health-promoting effects of THPs are reducible to the benefits of access to GAH.

Income as a health equity promotion resource

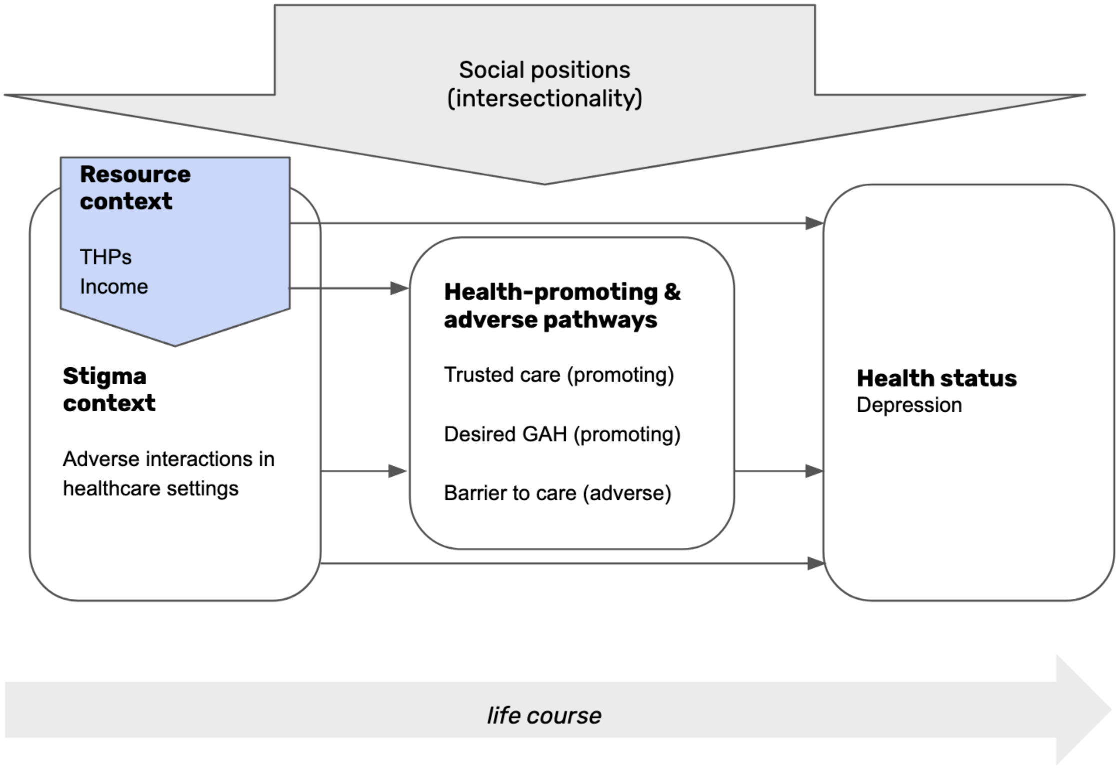
Income may be a protective factor, offsetting some of the most immediate barriers to accessing healthcare services. Researchers consistently find that costs and other economic factors are a significant barrier to timely access to healthcare services for trans people (James et al., 2016; Kcomt, 2021). Half of the participants in the TSHRJ survey indicated that costs were a reason they had delayed health care in the past year (Perez et. al., 2021). Among transmasculine people specifically, lower income is associated with greater exposures to discrimination in healthcare services (Shires et al. 2015) and with higher odds of depression (McDowell et. al., 2019). Given its potentially protective effects and its modifiability, this study analyzes income is a structural health resource rather than a background demographic characteristic.

Adapting the Health Equity Promotion Model for structural health equity

The Health Equity Promotion Model (HEPM) was developed by Fredriksen-Goldsen and colleagues (2014) to "reconceptualize" research related to LGBT health disparities. The authors build on existing frameworks, especially Minority Stress Theory and the Psychological Mediation Framework, which account for how stigma manifests in poorer health outcomes for LGBT people but situate these theories within a life course perspective. In doing so, the HEPM places emphasize how exposures to stigma accumulate differently over time and in relation to myriad health-promoting and adverse "pathways" that explain why some LGBT people (or subgroups thereof) may have better health outcomes than others. Thus, the model focuses researchers on studying within-group differences to identify advantages and health-promoting pathways that are benefiting some group members and may be extendable to others.

The adapted HEPM used in this study (Figure 1) incorporates the previously identified relationships between adverse interactions in healthcare settings, delayed healthcare seeking, and depression severity (Reisner et al., 2015b; Seelman et al., 2017a). To study the effects of THPs as a structural intervention, "resources" are distinguished from the mediating health-promoting pathways identified by the HEPM authors (i.e., behavioral, social, psychological, biological) (Fredriksen-Goldsen and colleagues, 2014). In the adapted model, THPs and income are entered as modifiable structural resources that may hypothetically: 1) prevent or reduce exposures to adverse interactions in healthcare settings; and 2) drive health-promoting pathways regardless of exposures to stigma, including access to a trusted care provider and desired gender-affirming medicine. Intersectionality, or the idea that multiple systems of oppression are interlocking, is represented as overarching the model and influencing all tested relationships and pathways (Fredriksen-Goldsen et al., 2014).

Figure 1: Adaptation of the Health Equity Promotion Model



Methods

This study uses survey data from the Transmasculine Sexual Health and Reproductive Justice Research Study (TSHRJ) in Los Angeles County, California. The TSHRJ was designed and collected as part of a participatory action research initiative in which more than forty people, mostly transmasculine BIPOC, contributed to survey development, outreach, and data analysis (Perez et al., 2021). The effort was led by an ongoing core team of researchers and organizers in collaboration with the University of California Los Angeles Department of Social Welfare and was approved by the University of California Los Angeles North Campus Institutional Review Board.

Sample and setting

Survey data were collected online between July to September 2017 using the Qualtrics Research Suite (Qualtrics, Provo, UT) and linked through an independent project website with information about the study and the community initiative. Eligible survey participants were ages 18 or older; assigned female at birth; trans men or on the transmasculine spectrum; and living, working, or receiving healthcare services in Los Angeles County. The survey was advertised through trans-led and LGBT community organizations and groups, physical outreach at events and venues throughout the county (e.g., clubs/bars, cafes, bookstores, salons, gyms), and social media advertising (e.g., Facebook, Twitter, Instagram, Scruff). There were no financial incentives for survey participation; however, participants could enter an anonymous raffle and ten cash prizes were awarded over six weeks (prize amounts varied from $100 to $500). The survey took approximately 20 minutes with a completion rate of 92%.

This study differences in health between survey participants who had a transgender healthcare provider (THP) and those who did not. Using a community survey in a bounded geopolitical region with several sites of specialized care allowed the analysis to focus on the influence of THPs, conceptually, rather than the effects of a single clinic or provider. At the time of the survey, there were multiple sites of care for accessing a THP in Los Angeles County. This included, but was not limited to, two federally qualified health centers (one in an LGBT community-serving organization, one serving low income communities in South Los Angeles), a children’s hospital serving patients up to age 24, a coordinated program within a large health maintenance organization (HMO), a specialized team within a university medical system, a clinic in an academically affiliated non-profit hospital, and specialized care teams within student health services at two major universities. The analysis for this manuscript excludes 10 TSHRJ participants who were missing data because they had not accessed any health care services in the past three years.

Measures

Confirmatory factor analysis (CFA) was completed using empirical loadings on two theoretical latent constructs related to adverse interactions in healthcare settings and access to a trusted care provider. The constructs include items from two scaled measures developed for the TSHRJ-LA: a 7-item measure of Recent Experiences in Medical Settings and a 2-item measure related to Quality of Mental Healthcare. The items were developed drawing on the lived experiences of participants and prior research findings relating to the experiences of trans healthcare seekers (e.g., Lerner & Robles, 2017; Owen-Smith et al., 2016).

Stigma context

Adverse interactions in healthcare settings is a latent measure comprised of five items. Four items were derived from the Recent Experiences in Medical Settings (REMS) measure which followed the prompt: "In the last three years, how often have you had the following experiences in a medical care setting?" (never, rarely, sometimes, often, not applicable). Statements included: (1) "I was asked questions about my gender identity or body that were not appropriate to the situation"; (2) "Doctors or medical staff used the wrong pronouns for me"; (3) "Doctors or medical staff didn't listen to what I was saying"; and (4) "I felt like doctors or medical staff treated me with less respect than other patients" The fifth item was from the

Quality of Mental Healthcare (QHM) measure, which asked participants the extent to which they agreed or disagreed with the following statement: “I have had a negative experience with a mental health care provider(s) in the past” (strongly agree, agree, neither agree nor disagree, disagree, strongly disagree).

Health-promoting or adverse pathways

Trusted care is a latent measure including four items. Three were derived from the REMS. Statements included: (1) “I was comfortable talking about my gender identity;” (2) “Doctors or medical staff trusted my knowledge about my health needs;” and (3) “I was satisfied with the care I received.” The fourth item was from the QMH measure, which was a response to the statement: “I have received excellent care from a mental health care provider in the past.” (strongly agree, agree, neither agree nor disagree, disagree, strongly disagree).

Access to desired gender-affirming healthcare (desired GAH) was computed based on participants’ responses related to three forms of GAH: testosterone therapy, chest reconstruction (“top surgery”), and genital reconstruction (“bottom surgery”). Participants were asked if they had already received these forms of treatment and, if not, if they desired them in the future. Each item was dichotomized (1 = already accessed or does not desire; 0 = desires treatment but has not had access) to account for a gap in access. Items were added for a score range of 0-3, with 0 representing those who desired all three forms of care and had not had access to any, and 3 representing those who had already accessed each form they desired or did not desire any. The mean score was 2.23 (SD = .77).

Barriers to care was a continuous scale of participant responses to the prompt: “In the last twelve months, have you ever delayed seeking medical care for any of the following reasons?” Fourteen items were offered based on barriers already identified in the research literature (Lerner & Robles, 2017) and by the community research team. These included (listed in order of most frequently selected): 1) cost (50%); 2) anxiety related to previous health care experiences (47%); 3) concern about mistreatment based on gender identity or expression (44%); 4) lack of trust in medical providers (37%); 5) do not want a physical examination (32%); 6) can't get time off work (31%); 7) concern about mistreatment based on mental health symptoms or diagnoses (23%); 8) lack of healthcare insurance (20%); 9) concern about mistreatment based on race or ethnicity (16% among BIPOC participants only); 10) lack of transportation (13%); 11) lack of accurate identification documents (9%); 12) lack of housing (4%); 13) lack of physical mobility (4%), and 14) lack of childcare (1%). One item, "depression/lack of motivation," was removed from this analysis because it lacked conceptual independence from the outcome measure, although notably, it was the most frequently selected item (51%). Scores were computed by adding the number of barriers selected. Participants who selected "I have not delayed seeking health care in the last twelve months" (n=32) or who only selected depression/lack of motivation (n=8) were coded as 0. Most participants had delayed health care in the past year for at least one reason (87%). Participants' scores ranged from 0 to 11 with a mean score of 3.35 (SD = 2.54).

Structural health-promoting resources

Having a transgender-specific healthcare provider (THP) was a dichotomized variable (1 = yes, 0 = no or don't know) based on participants' responses to 1) whether they had a primary care provider (PCP) as defined as "regular health care provider that is certified to diagnose and treat physical/medical symptoms" (yes, no, don't know); and. if yes, 2) "Does your PCP specialize in transgender health care services?" (yes, no, don't know). Twenty participants answered "don't know" to the second item and each case was individually reviewed. Seven were recoded to “yes” because they indicated a usual source of care with a known transgender health program (i.e. the Los Angeles LGBT Center).

Income was measured as an ordinal variable based on a question about monthly income with five response categories (1= less than \$500; 2= \$500-\$999, 3 = \$1,000-2,999; 4 = \$3,000-4,999, and 5 = \$5,000 or greater). Income is treated as continuous in the model with a mean score of 2.96 (SD = 1.26).

Health outcome

Depression was calculated using the nine-item Patient Health Questionnaire (PHQ-9), a previously validated measure of depression severity (Kroenke & Spitzer, 2002). The measure follows the prompt “Over the last 2 weeks, how often have you been bothered by any of the following problems?” with each item representing a symptom (e.g., “little interest or pleasure in doing things,” “feeling down, depressed, or hopeless”). The final scale ranges from 0 to 27 with each item scored from 0 (not at all) to 3 (nearly every day). Scores of 10 or greater indicate moderate to severe depression (Kroenke & Spitzer, 2002). Depression is treated as a continuous variable, with scores ranging from 0 to 27 and a mean score 9.10 (SD = 6.46; Cronbach’s ɑ = .91).

Social characteristics accounted for in the structural equation model

Age was answered in years. Participants ranged in age from 18 – 67, with a mean age of 29.66 (SD = 7.84). *College* was calculated as a dichotomous variable for formal educational attainment (1 = four-year college degree or more, 0 = less than a four-year degree). More than half of participants had a college degree (53%). *BIPOC* was calculated as dichotomous measure for white privilege and racial minoritization (1 = Black, Indigenous, Latinx, Native American, Middle Eastern, North African, Asian, Pacific Islander, Native Hawaiian, multiracial participants; 0 = only White). More than half of the participants were BIPOC (58%). Participants who responded “prefer not to say” on social characteristic measures were treated as missing.

Social characteristics included in the sample description

Disability was calculated as a dichotomous variable based on the question “Do you identify as having a disability” (1 = yes; 0 = no). *Racial/ethnic identity* was grouped based on a multiple selection item as: Native American, Black, Asian, Pacific Islander, Native Hawaiian (API&NH), Latinx, multiracial and white. Participants who selected more than one category, or wrote in additional identities, were categorized as Latinx if they selected Latinx (or wrote in Chicanx or Chicano) or multiracial if they did not. *Testosterone* was calculated as a dichotomous variable based on the question “Do you currently use testosterone” (1 = yes; 0 = no). *Top surgery* was calculated as a dichotomous variable based on the question “In the course of your lifetime, have you had access to: “top surgery” (mastectomy, chest reconstruction, etc.)?” (1 = yes; 0 = no).

Data analysis plan

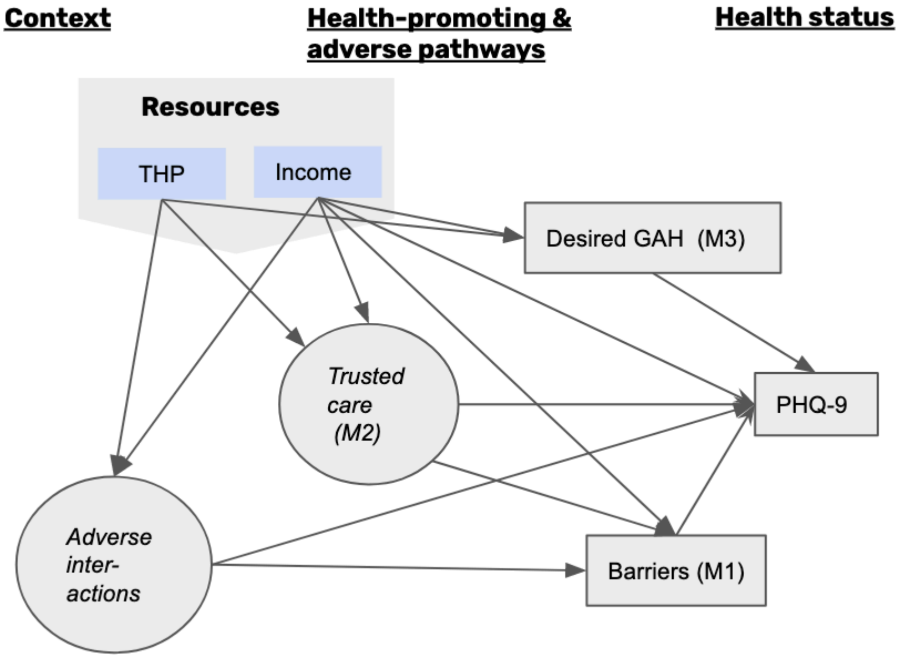
All observed items were examined and assessed descriptively. First, the distribution of characteristics between participants with a THP and without a THP were compared using chi-square tests of independence and independent sample t-test for mean score differences. Next, confirmatory factor analysis was conducted to test associations and ensure a good fit between the observed items and two theoretically constructed latent variables for adverse care and trusted care. Error terms for manifest variables were allowed to correlate if there was sufficient theoretical justification and improvement in model fit. A correlation matrix of unstandardized coefficients was produced to further explore the covariance structure between all observed continuous study variables before a hypothesized structural model (Figure 2) was fitted to the data using maximum likelihood estimation to test study hypotheses (Table 1).

Table 1: Study hypotheses

Q1.	How is having a THP related to depression severity (PHQ-9 scores)?
H1a	THPs reduces *adverse healthcare experiences*, which in turn reduce *barriers to care* (M1) which are associated with *depression.*
H1b	*Trusted care* (M2) mediates the relationship between THPs and reduced *depression*.
H1c	*Trusted care* (M2) mediates the relationship between THPs and reduced *barriers to care* (M1), which are associated with *depression*
H1d	*Access to desired GAH* (M3) mediates the relationship THPs and reduced *depression.*
Q2.	How is income related to depression severity (PHQ-9 scores)?
H2a	Higher income reduces *adverse health care experiences*, which in turn reduce *barriers to care* (M1) which are associated with *depression.*
H2b	*Barriers to care* (M1) mediate the relationship between higher income and reduced *depression*.
H2c	*Trusted care* (M2) mediates the relationship between higher income and reduced *depression.*
H2d	*Trusted care* (M2) mediates the relationship between higher income and fewer *barriers to care* (M1), which are associated with depression
H2e	*Access to desired GAH* (M3) mediates the relationship between higher income and reduced depression.

Note: THP = Transgender healthcare provider; GAH = gender-affirming healthcare; M = mediator.

Figure 2. Hypothesized effects of having a THP and income on PHQ-9 scores.



THPs and income are hypothesized as a structural resources, and each are treated as independent predictors of PHQ-9, with hypothesized pathways specified to determine whether this relationship is explained by reduced stigma (fewer adverse interactions in health care settings), greater access to trusted care (M1), barriers to care (M2), or access to desired GAH (M3). Age, BIPOC, and college are examined covariate measures in every tested pathway. Disability was not included in the full model because an examination of participant write-in responses suggested that the construct lacked sufficient independence from the study outcome (i.e. some reported depression as a disability). Single-item manifest variables were entered for both THP (binary) and income (ordinal) as exogenous variables, and barriers to care (continuous), desired GAH (continuous), and mental health (continuous) as endogenous variables. Practical indices of goodness of fit were examined alongside chi-square (χ^2) statistic.

Model fit was evaluated based on Comparative Fit Index and Tucker-Lewis Index (CFI/TFI) of .95 or larger in combination with root mean square error of approximation (RMSEA) and the standardized root mean square residual (SRMR) .05 or lower as close or excellent fit (Kline, 2015). In the case that model fit was less than acceptable, modification indices were examined for correlated error terms that would justify re-specification to improve model fit. Finally, I examined the amount of variance in the outcome variable that was accounted for by the model and indirect effects were computed using bootstrapping with a total of 5,000 samples randomly generated to 95% standardized confidence interval for all indirect effects of THP and income on depression. All analyses were performed using the "lavaan" package in R (4.1.1) and utilized full information maximum likelihood estimation with robust standard errors.

Results

Participants were diverse in terms of their gender identity with 49 unique terms identified and the most common "best" terms were: trans man (20%), trans or transgender (17%), transmasculine (14%), non-binary (13%), man or male (11%), and genderqueer (8%) (with the remaining 17% selecting or writing in another term, e.g., two-spirit, FTM, agender, bigender, trans dude, stud, etc.). They were also diverse in terms of racial and ethnic identity; Native American (15), Black (7%), Latinx (27%), API&NH (12%), Middle Eastern (2%); multiracial (11%) and White (42%). They were largely low-income with 32% reported income under the federal poverty guideline in 2017 (U.S. Department of Health and Human Services, n.d.). More than half of all participants, and 64% of participants who were ages 25 or older, had obtained a college degree.

Preliminary comparisons

The characteristics of participants including comparisons between participants with a

THP (37%) and without a THP (63%) at the time of the survey are shown in Table 2.

Table 2: Transmasculine adult participants in Los Angeles County (n=300)

	THP (n = 112)		**No THP** (n = 188)		**Full sample** (n = 300)	
	M.	SD	M.	SD	M.	SD
Barriers to care***	2.66	(2.21)	3.70	(2.21)	3.31	(2.53)
PHQ-9 scores*	8.11	(5.58)	9.67	(6.93)	9.09	(6.50)
Social characteristics						
Age (mean)	29.75	(8.73)	29.66	(6.32)	29.70	(7.91)
	n	%	n	%	n	%
BIPOC (yes)	62	55.4	108	57.8	179	56.9
College degree (yes)	59	52.7	98	52.4	157	52.5
Disability (yes)	33	30.8	68	37.8	101	35.2
Racial/Ethnic Identity[a]						
API&NH	11	10.1	23	12.6	34	11.7
Black	7	6.4	12	6.6	19	6.5
Latinx	30	27.5	48	26.4	78	26.8
multiracial (non-Latinx)	11	10.1	20	11.0	31	10.7
White	50	45.9	79	43.4	129	44.3
Monthly Income						
< $500	19	17.0	31	16.8	50	17.1
$500-999	16	14.8	28	15.2	44	15.1
$1,000-2,999	44	40.7	64	34.8	108	37.0
$3,000-4,999	17	15.7	30	16.3	47	16.1
< $5,000	12	11.1	31	16.8	43	14.7
Has accessed GAH						
Testosterone (yes)***	104	92.9	116	61.7	220	73.3
Top surgery (yes)*	63	56.3	83	44.1	146	48.7
Prefers specialists[b]						
Agree	108	96.4	150	90.4	258	92.8
Does not agree	4	3.6	16	9.6	20	7.2

Note: M and SD are used to represent mean and standard deviation, respectively. GAH = gender-affirming healthcare. Sample sizes vary due to non-response. * p < .05. ** p < .01. *** p < .001.

[a] Due to small group sizes, comparisons do not include participants who identified as only Native American (3 of 3 had a THP) or only Middle eastern (5 of 5 did not have a THP).

[b] 22 participants did not report provider preferences because they indicated “I do not usually seek out health advice or treatment” (22 of 22 did not have a THP).

Participants with a THP indicated significantly lower mean scores for the barriers to care measure and PHQ scores when compared to non-THP participants. Participants with and without a THP did not otherwise statistically significantly differ by income or by the other examined social and demographic characteristics. However, a greater portion of THP participants had accessed testosterone and top surgery compared to participants without a THP.

Measurement model: Confirmatory factor analysis (CFA)

The nine items loaded into the respective latent constructs of adverse care and trusted care experiences and all loadings were statistically significant ($p < .01$). The model fit to the data was fair with modification indices suggesting a covariance structure between one adverse item (i.e., “providers asked questions about my body or gender identity that were not appropriate to the situation”) and one trusted care item (i.e., “I was comfortable talking about my gender identity”). Given the conceptual links between these two gender-related items, the model was respecified to allow covariance between the two items and fit indices suggested a good fit to the data (χ^2(25=43.18, p = 0.01.; CFI = .978, TLI = .969, RMSEA = .049 [CI: .022, .073], SRMR = .031). The complete list of items, loadings, and squared multiple correlations (SMCs) are included in Table 2. The lower factor loadings on mental health care (MH) experiences suggested that these experiences were less salient to the overall latent concept, although a comparative analysis of model fit without these items indicated a statistically significantly stronger model fit when MH items were included. The estimated correlations among all observed continuous variables are shown in Table 3.

Table 3. Confirmatory factor and reliability analysis

A. Estimates of loadings

Constructs	M	SD	Factor loadings	SMC (R^2)	Cronbach alpha
Adverse interactions in healthcare settings					.78
Q3. I was asked questions about my gender identity or body that were not appropriate to the situation.	2.25	1.06	.57	.32	
Q4. Doctors or medical staff used the wrong pronouns for me.	2.72	1.08	.65	.43	
Q5. Doctors or medical staff didn't listen to what I was saying	2.43	1.01	.88	.77	
Q7. I felt like doctors or medical staff treated me with less respect than other patients.	2.08	.98	.80	.64	
MH2. I have had a negative experience with a mental health care provider in the past.	3.92	1.12	.33	.11	
Trusted care provider					.72
Q1. I was satisfied with the care I received	3.18	.74	.70	.49	
Q2. I was comfortable talking about my gender identity	2.83	.97	.69	.47	
Q6. Doctors or medical staff trusted my knowledge about my health needs	3.06	.83	.72	.52	
MH1. I have received excellent mental health care in the past.	3.84	1.2	.40	.16	

B. Covariance of measure error

Measurement variables	covariance
Q2 & Q3	-.27

Note: M=Mean, SD = standard deviation, SMC = square multiple correlations. All Q items are scaled 1-4 (1= never, 2 = rarely, 3 = sometimes, 4 = often). All MH measures are scaled 1-5 (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree; 5 = strongly agree). Cronbach's alpha is standardized. All factor loadings and covariance structures were significant at p <.001.

Table 4: Means, standard deviations, and pairwise correlation coefficients for continuous study variables

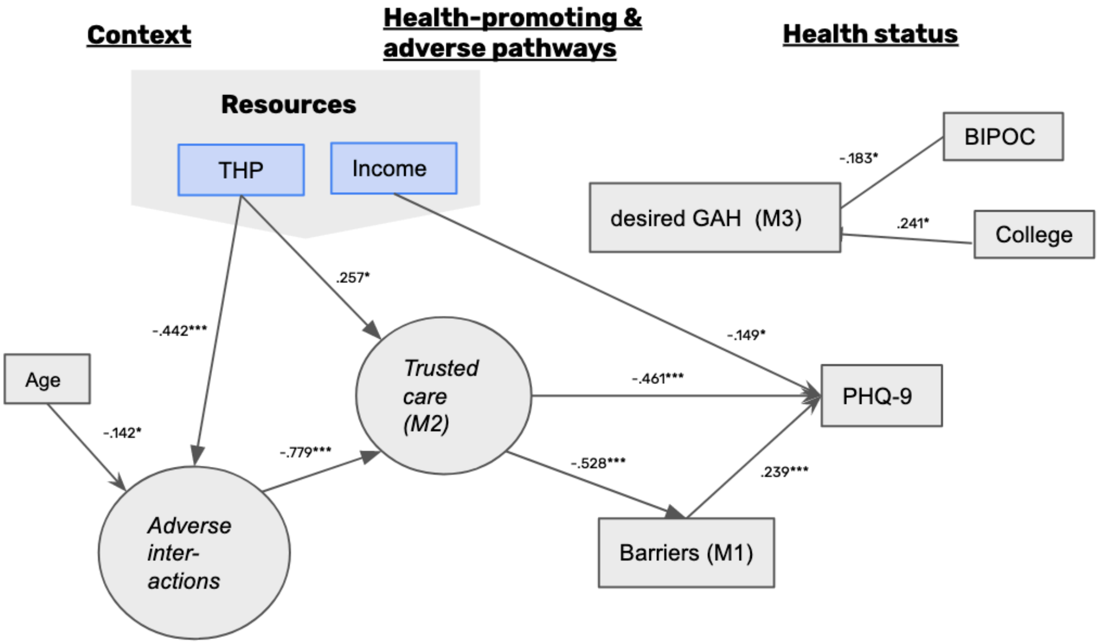
Variable		M	SD	1	2	3	4	5	6	7	8	9	10	11	12	13
1.	PHQ-9	9.09	6.50													
2.	Age	29.7	7.91	-.27**												
3.	Income	2.96	1.26	-.27**	.39**											
4.	GAH	2.23	0.77	-.10	.12*	.15*										
5.	Barriers	3.31	2.53	.49**	-.18**	-.20**	-.02									
Adverse interactions																
6.	REMS-3	2.25	1.06	.12	-.03	-.03	-.00	.31**								
7.	REMS-4	2.72	1.08	.30**	-.21**	-.12	-.13*	.38**	.35**							
8.	REMS-5	2.43	1.01	.32**	-.09	-.09	-.04	.42**	.48**	.60**						
9.	REMS-7	2.08	0.98	.33**	-.16**	-.11	-.01	.45**	.52**	.49**	.71**					
10.	QMH-2	3.92	1.12	.19**	-.07	-.00	.08	.31**	.28**	.26**	.26**	.21**				
Trusted care																
11.	REMS-1	3.18	0.74	-.33**	.04	.09	.05	-.45**	-.34**	-.35**	-.48**	-.47**	-.20**			
12.	REMS-2	2.83	0.97	-.37**	.16**	.08	.06	-.36**	-.15*	-.44**	-.47**	-.40**	-.20**	.51**		
13.	REMS-6	3.06	0.83	-.39**	.14*	.10	.07	-.46**	-.31**	-.34**	-.57**	-.52**	-.22**	.48**	.50**	
14.	QMH-1	3.84	1.20	-.22**	.10	.03	.11	-.35**	-.19**	-.17**	-.27**	-.33**	-.17**	.29**	.26**	.32**

Note. M = mean; SD = standard deviation, PHQ-9 = nine-item patient Health Questionnaire, GAH = (desired) gender affirming healthcare; REMS = Recent Experiences in Medical Settings; QMH = Quality of Mental Healthcare. * p < .05 ** p < .01.

Structural Equation Models

The initial model fit was not acceptable with modification indices indicating an unaccounted for relationship between adverse interactions and trusted care. An additional pathway was specified to test a hypothesized relationship in which adverse interactions negatively predict trusted care and model fit indices suggested an acceptable fit to the data (χ2(83=119.390, p = 0.005; CFI = .965, TLI = .948, RMSEA = .039 [CI: .022, .054], SRMR = .036. The final model is shown in Figure 3 with all statistically significant effects.

Figure 3. Path diagram explaining the effects of THPs and income on depression (PHQ-9)



Note: Standardized coefficients are presented. Model included age, BIPOC, and college as covariants in every examined pathway; only statistically significant pathways are displayed. CFI = .97, TLI = .95, RMSEA = .039 [.022, .054]; SRMR = .036. *P <. 05 **P < .01, ***P ≤ .001.

Confidence intervals of all indirect pathways are displayed in Table 5. Age was the only examined sociodemographic characteristic that was (negatively) associated with adverse health care experiences. Being white and having a college degree were both positively associated with access to desired GAH. Participant social characteristics were otherwise not statistically significant and are not depicted in the figure. The model accounted for 67.1% of the variance in trusted care, 39.5% of the variance in barriers to care, 6.9% of the variance in desired GAH, and 35.1% of the variance PHQ-9 scores.

Table 5. Indirect effects linking THPs and income to depression (PHQ-9) using bootstrap analysis with a 95% confidence interval

Q1. The relationship of having a THP and depression	Estimates	95% CI
1a. THP → adverse → barriers → PHQ-9	-.051	-.292, .130
1b. THP → trusted care → PHQ-9	**-.77**	**-1.631, -.037**
1c. THP → trusted care→ barriers → PHQ-9	**-.21**	**-.45, -.011**
1d. THP → desired GAH → PHQ-9	-.00	-.102, .086
Model-implied		
THP → adverse care → trusted care→ PHQ-9	**-1.027**	**-2.671, -.170**
THP → adverse care → trusted care → barriers → PHQ-9	**-.28**	**-.611, -.062**
Total indirect effects of THP on PHQ-9	**-1.85**	**-2.839, -.84**
Q2. The relationship between income and depression	Estimates	95% CI
2a. Income → adverse care → barriers → PHQ-9	-.01	-.057, .024
2b. Income → barriers → PHQ-9	-.12	-.282, .025
2c. Income → trusted care → PHQ-9	-.01	-.330, .310
2d. Income → trusted care → barriers → PHQ	-.00	-.095, .080
2e. Income → desired GAH → PHQ-9	-.00	-.074, .063
Model-implied		
Income → adverse care → trusted care→ PHQ-9	-.14	-.532, .121
Income → adverse care → trusted care → barriers → PHQ-9	-.04	-.139, .031
Total indirect effects of income on PHQ-9	-.25	-.648, 0.214

Note: Unstandardized coefficients reported. THP = Transgender healthcare provider; PHQ-9 = Nin-item Patient Health Questionnaire; GAH = gender-affirming care.

Indirect effects of THPs on PHQ scores

Figure 3 shows how having THP was negatively associated with adverse care (e.g., intrusive questions, being treated with less respect, etc.) and positively associated with trusted care (e.g., comfortable sharing gender, satisfied with care, etc.). The effects of a THP on depression severity scores were explained by reduced exposures to adverse care, increased access to trusted care, and reduced barriers to care. The relationship between having a THP and fewer adverse care experiences did not predict lower PHQ-9 scores except to the extent that fewer adverse care experiences were associated with greater access to trusted care. Contrary to hypothesis 1d, having a THP was not statistically significantly associated with desired GAH, and desired GAH was not associated with depression severity.

Effects of Income on PHQ scores

Income was directly negatively associated with PHQ-9 score, and this relationship was not explained by any of the tested pathways, including adverse care experiences, trusted care, access to desired GAH, nor reduced barriers to care.

Discussion

The study offers some of the first known data on the desirability, uptake, and individual-level health benefits of having access to specialized transgender health providers (THP) in a bounded geographic area. Most transmasculine participants in Los Angeles County preferred THPs but only 37% had THP for primary care indicating a significant gap in access in the period preceding the implementation of state funding for services. Gaps in the uptake of THPs were not explained by any of the demographic comparisons explored in this study. Participants with and without a THP did not appear to differ on measures of age, income, racial and ethnic identity, educational attainment, or disability; however, these findings are cautiously interpreted in context, as sample sizes were relatively small, and the region includes a flagship children's hospital program serving young people up to age 24 and a transgender clinic serving low-income patients with a BIPOC-led care team. Additional research is warranted to understand racial, ethnic, and class inequities in access to trusted providers and gender-affirming care, particularly given this study's findings that being white and having a college degree (but not age) were associated with access to desired gender-affirming medicine, and prior evidence that trans people of color experience challenges finding providers whose practices are both anti-racist and gender-affirming (Agénor et al., 2022; Howard et al., 2019).

Transgender health services as a health equity strategy and community-level resource

Broadly documented patterns of mistreatment of transgender people in healthcare services has resulted in recommendations for broad-based training for medical students and professionals (Nolan et al., 2020). Common approaches tend to follow a "diversity" model in which instruction focuses on working with trans patients as a special population, a woeful substitute for the kinds of transformative structural changes needed to address institutional exclusions (Hanssmann, 2012; van Heesewijk, 2022). Transgender health care clinics and specialists are expanding in a time in which a growing number of people are seeking access to affirming approaches to care that are largely unrealized in mainstream settings. Designated services for transgender health care cannot resolve structural problems underlying unequal access to care or the fundamental causes of health inequities. They are an immediate strategy with considerable community support, and as this study suggests, are highly desirable and able to mitigate some of the problems trans people face in mainstream health care settings.

In this study, having a THP was associated with trusted care, a latent factor that included comfort and overall satisfaction with care received. Trusted care was the core health-promoting mechanism linking THPs to reduced depression severity. While the final model showed THPs were also associated with fewer exposures to adverse or hostile healthcare interactions (often the primary goal of provider training programs), this did not have a health-promoting effect except to the extent that it was associated with the trusted care measure.

Most participants with a THP utilized testosterone (93%) compared to less than two-thirds of those without a THP (62%), and a greater portion of participants with a THP had top surgery compared to those without a THP. This might lead to the conclusion that having a THP is associated with greater access to desired GAH, however, this explanation was well not supported in the full model. In fact, a college degree and being White (vs. BIPOC) were both associated with access to desired GAH while THPs were not. One explanation might be the reverse inference, that those who desired GAH were more likely to seek out a THP. The finding might suggest those who do not desire GAH (and especially testosterone) may not view themselves as eligible or the intended beneficiaries of THPs, despite a preferences for THPs across the sample. Notably, access to desired GAH was not associated with depression. While this should be interpreted cautiously given previously established connections between GAH and better mental health (e.g., Alamazon et al., 2021, Tomita et al., 2019), however future research might refine measures that accounting for differences in desire and access to GAH. The findings here amplify this study's central finding that THPs are efficacious for health equity promotion because of their capacity to mitigate harm in healthcare settings, increase access to a trusted care provider, and reduce barriers to care. Further research might explore this hypothesis with other kinds of health outcomes.

The study advances measurement strategies related to barriers to care by using a multi-item measure developed by community organizers. Analyzing responses as a scale, rather than a binary item, contributes to interpretations of results that focus on reducing barriers rather than eliminating them. This may be a more accurate depiction of the goals of THPs as a structural strategy given the much broader transformative social changes needed to create barrier-free access to healthcare for all. This study confirms Seelman and colleagues (2017a) findings that the relationship between adverse healthcare experiences and negative health outcomes may be by increased delays or barriers to care. Yet the relationship between trusted care and better health outcome was only partial explained by barriers to care, suggesting additional and unaccounted for benefits. Additional research is warranted to further explain the relationship between THPs and better mental health including the social benefits of being connected to other trans people through health care organizations.

Income as a health promotion pathway

Income was hypothesized as a health-promoting resource with the potential to reduce barriers care; however, this did not bear out in the data. Income was directly associated with lower depression scores and this effect was unexplained by any of the hypothesized pathways, including reducing barriers to care, accessing trusted care providers, and accessing desired GAH. This finding is consistent with research connecting income to depression in the general population (Patel et al., 2018) and among trans people specifically (McDowell et al., 2019; Seelman et al., 2017b). Additional research is warranted with a sample with greater income variation, however, the finding in this study suggests that among lower-income groups the relationship between poverty level income (the lower ends of the scale) and depression severity are not mediated by reduced access to health care.

Wealth is a well-established and influential social determinant of health (Silva et al., 2016). Trans people experience high rates of poverty and unemployment that exceed general population estimates by at least 10% (Crissman et al, 2017; Leppel, 2021), and trans men and trans people of color are especially impacted (Fredriksen-Goldsen et al., 2022; Badgett et al., 2019; Wilson et al., 2020). For example, Wilson and colleagues (2020) found that gender bias, racial discrimination, and parenting-related challenges were all salient factors influencing poverty among trans men of color participants in Southern California. Recent calls to pilot Universal Basic Income (UBI) programs focused on trans people have gained momentum among community groups in California (Diaz, 2022). UBI pilot programs using unconditional cash transfers have had demonstrably efficacious results in terms of positive mental health in other groups (Wilson & McDaid, 2021), offering a promising direction for future research and health equity advocacy for trans people.

Limitations

The cross-sectional study design limits the ability for causal inferences between the primary predictors and outcomes. This limitation was mitigated in part by constructing a model with temporally specific measures (i.e., health care experiences were measured as cumulative over the past 3 years, often to never; reasons for delaying care were specified as “in the past year”; depression symptoms were tied to the past two weeks). However, it remains plausible that depression severity could influence participants’ access uptake of THPs, perceptions of health care encounters, and indicated barriers to care. The community-developed item “lack of motivation/depression" (as a reason for delaying care) was the single most selected item with more than half of study participants selected it. This might suggest that the relationship between delayed care and depression may be a more dynamic than strictly predictive one. Longitudinal research studies are needed to better understand the influence of health care experiences over time, including engagements with THPs. Likewise, the relationship between adverse interactions in health care and trusted care experiences was specified in the model such that adverse care was predictive, however, this relationship may also be more dynamic than linear. Future research studies might also continue to delineate and investigate the relationship between simply eliminating harms in health care services (e.g., misgendering, inappropriate questions) and the delivery of high-quality care (e.g., patient satisfaction, trust).

The TSHRJ survey data draws on a non-probability convenience sample of transmasculine participants in an online survey conducted in English only. Compared to the demographic characteristics of trans participants in the California Health Interview Survey, a state-level random phone survey conducted in 2015-2016, a greater portion of participants in the TSHRJ survey were Black, Latinx, and multiracial (and fewer were white and Asian) and a greater portion had completed a 4-year college education (Herman et al., 2017). Sufficiently large sample sizes in a single region remain difficult and cost-prohibitive to obtain through probability sampling methods. While the convenience sampling approach used in the TSHRJ is not representative of transmasculine people in California, this limitation is balanced with the benefits of locally specific and participatory research design. For example, participants were able to select named sites of care which improved measurement quality. Further, the overrepresentation of Black, Latinx, and multiracial people is valuable given the current underrepresentation of transmasculine BIPOC participants in crafting and participating in transgender health research studies (Cicero et al., 2019; Edmiston et al., 2016; Farvid et al, 2021) and the need to account for how racism may limit the benefits of trans-specific, but not racially or culturally-specific, forms of care. The limited findings with respect to the social advantages of being white or having a college degree on healthcare experiences should be interpreted cautiously given that the binary indicator flattens considerable heterogeneity.

Additional research is needed to better represent geographic, as well as racial, cultural, and class diversity across the state and to examine the influence of state funding and the COVID-19 pandemic on overall health and health care utilization patterns. Qualitative explorations of the differences between emerging models and types of providers are also relevant to the development of the transgender health services sector as practices continue to diversify, with particular attention to approaches that meet the needs of trans people with multiple marginalized identities.

Conclusion

Despite limitations, this study provides evidence in support of community-driven demands for transgender-specific health care services and universal basic income programs as health equity promoting strategies. The effects of having a transgender health care specialist on mental health among participants in this study were explained by a measure of higher-quality care and reduced barriers to care and indicated that the benefits of specialist transgender health care sites are not reducible to access to gender-affirming medicine. Income was directly tied to depression in this study, and this relationship was unrelated to health care measures, suggesting the need for supportive economic initiatives beyond those that focus on health care. Future research on the community-level benefits of community-based THP models, as well as the individual-level benefits of THPs on trans people living in under-resourced regions, trans women and people with nonbinary identities, and a focused study with trans people living with chronic health conditions or disabilities that require specialized care would be useful to the development of THP models to maximize their reach and benefits. While significant gaps remain in identifying resources and strategies for mental health promotion tailored for transmasculine adults, transgender health care services and basic income programs offer two directions of actionable structural health equity strategies with community support in California and beyond.

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Chapter 5: Conclusion

Over the course of writing this dissertation, the stakes of conducting research related to transgender health gained a sense of urgency as anti-trans rhetoric became a galvanizing force in U.S. politics. In 2016, the same year that the NIH designated trans people a "health disparity population" and I joined a group of community organizers in Los Angeles County to develop an initiative on transmasculine health justice, the North Carolina state legislature passed a first-of-its-kind "bathroom bill" that effectively banned trans people from accessing public facilities (Murib, 2020). Although the bill was partially repealed the following year, the surrounding media attention demonstrated the issue's potential to rile a conservative base. Today, a coordinated attack on trans people has taken shape in state legislatures and local municipalities and school boards. From book bans to restrictions on athletic participation, an explicitly anti-trans agenda has emerged within a broader "anti-woke" politics, fueled by the Trump presidency and the mainstreaming of white heteropatriarchal ethnonationalism, designed to quell the cultural and political influence of antiracist, feminist, and queer and trans social justice movements (Cammaerts, 2022).

As of 2022, the American Civil Liberties Union (n.d.) was tracking more than 300 proposed state policies targeting LGBT people, including efforts to prohibit access to gender-affirming healthcare interventions for minors in twenty-one different states. The passage of statewide restrictions in states like Florida and Texas have demonstrated the slippage between limiting rights to gender-affirming healthcare and limiting the rights to be a trans person. Hastened by popular and pseudoscientific discourses of social contagion theories, this policy context has marked a swift shift from the (momentary) recognition of public health crises facing trans people to allegations that trans people *are* the public health crisis (Ashley, 2020; Hsu, 2022).

At the same time, arguments advanced to protect access to gender-affirming healthcare interventions also bear confounding social and political implications for trans people. Narratives of trans identity as biological and innate tend to lean into, rather than debunk, notions of transness as rooted in individual pathology (Sudai et al., 2022). Claims that gender-affirming healthcare interventions are ethical *because* medical experts authorize and supervise them have continued to entrench biomedical authority over trans lives and ensuing clinical paternalism (Wuest, 2018). The use of statistics related to the prevalence of depression and suicidality both relies on and produces a need for more scientific proof that gender-affirming healthcare interventions are beneficial. Such research tends to center the experiences of trans people who desire and can move into more privileged social positions, obscuring the ongoing stressors of stigma, racialized targeting, structural exclusions, and care labor that maldistribute life chances. Further, the focus on creating evidence to prove gender-affirming healthcare has mental health benefits can undermine the work of trans activists to secure access to these forms of medicine as a human right (Schwend, 2020).

In the recent rash of anti-trans legislation, political opponents narrowly define "transgender health care" as *synonymous* with gender-affirming surgeries and hormone therapies to gain regulatory control. Likewise, speculative investments in a growing transgender healthcare market have contracted the category of "transgender health care" to extract profit. Thus, a central catalyst of this dissertation was a need for expanding notions of "transgender health care" in ways that refuse its governability and can respond to the root causes of health inequities. This study explores a different set of coordinates for understanding twenty-first-century transgender health care as it is negotiated by trans people in health clinics, practiced in communities, and mobilized for resource redistribution through state policy to confront institutions and build social power.

Taken together, “Compelling Care” offers three critical redirections within emergent trans health justice research and health care practices. First, a patient-driven perspective challenges liberal impulses to secure expertise by positioning providers as best positioned to reform institutional problems and erasing the role that patients (and, therefore, trans communities and social movements) have and do play. A patient-driven theory of bottom-up social change importantly intervenes in a dominant prescription for solutions that require institutional agreement. A theory of compelling care shows how decentralized acts of self-defense reflect and formulate a broader social phenomenon for institutional change.

The second is developing the social care practices in trans communities as transgender health care. This not only aids in the advancement of holistic and community-centered care frameworks that center the knowledges and practices of trans people, Black and Indigenous people, people with disabilities, and those at the intersections. A health justice framework can importantly name the maldistribution of care labor between community care work and the logics of securing the market for delivering transgender health care within the medical-industrial complex. In Chapter 2, I demonstrated how social and political interdependence produces forms of collective protection in institutional medicine. In Chapter 3, I showed how relational practices outside of healthcare institutions forge and facilitate social and political interdependence as a foundation for and form of community care. A focus on transmasculine social care work among Black and Indigenous people and other people of color importantly expands notions about who is most burdened by racialized gendered stratifications of care labor and the possibilities produced by transmasculine caretaking.

Finally, this dissertation demonstrated some of the ways in which “transgender health care” can be mobilized to build community power and solidify a demand for the redistribution of health care resources. The call to publicly fund transgender-specific healthcare services in California is a community-developed structural health equity intervention that not only responds to health inequities but refuses for-profit market expansion seeking to commodify “inclusive” healthcare. Rather than seeing transgender health care clinics as siloing patients into substandard care, Chapter 4 offers supportive evidence of how this institution-building practice produces better forms of caring. This historically specific redistributive strategy provides lessons for social justice health care policy and practice more broadly.

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