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Sexual Identity, Behavior, and Risk Among Female-to-Male Transgender Persons

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Sexual Identity, Behavior, And Risk Among Female-to-Male (FTM) Transgender Persons

by

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DISSERTATION

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Abstract

Female-to-Male transgenders (FTM), or transmen, have become an increasing presence in the gay community, especially in San Francisco. However, there is little data regarding how they transitioned into the gay community and the risks for HIV and STDs that they faced when they completed transition. This dissertation is comprised of four papers that examine that situation. The first paper describes the ways in which three decades of the HIV epidemic have impacted sexual behavior and attitudes within the gay community. That is followed by a review of what is known and unknown about the development of sexual differentiation and gender identity, with a specific focus on a variety of intersex conditions. The final two papers present the results of the study "Sexual Identity, Behavior, and Risk Among Female-to-Male Transgender Persons". This study used Interpretive Phenomenology to describe and understand the experience of 17 transmen who were recruited in the San Francisco area. Two lines of inquiry were identified for the study. The first was to describe and understand the variability in sexual orientation and behavior among transmen before and after transition and the use of testosterone. The four distinct groups of steadfast, shifted, aligned, and fluid are identified and described in the third paper. The final paper examines the second line of inquiry. This was to identify the risk present for transmen who transitioned into the gay community. Risks inherent in being part of the gay community as well as aspects of risk that are specific to transmen are discussed.

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Introduction

This dissertation, “Sexual Identity, Behavior, and Risk Among Female-to-Male (FTM) Transgender Persons”, is concerned with FTM, or transmen, and how the position of many of them within the gay community has implications for risk for HIV and STDs. However, in order to fully appreciate the climate of risk within the gay community today it is necessary to briefly describe some of the ways in which the current gay community is different from the one that was initially devastated by HIV.

As the HIV epidemic enters its third decade in the United States, changed attitudes toward the disease within the population of MSM can be observed. Not only has the passage of time affected the way that MSM have adapted to the presence and threat of HIV, it has allowed for changes in the MSM population that could not have been anticipated in the early 1980s. These changes reflect, in part, a maturing of the gay community but also present challenges to effective prevention messages and interventions.

Despite that fact that the epidemic eliminated a great portion of a generation of gay men, the community has shown signs of aging that were not apparent when HIV was first identified. Certainly some of the visible aging is due to the fact that improved treatments have granted longer lives to those infected with the virus (Emery et al., 2008). This has been at the cost of recognizable physical changes that have also affected the gay community. The effects of lipodystrophy (Onen et al., 2010) have become a common sight in cities such as San Francisco where the HIV prevalence among gay men is estimated to be 24.3% (Scheer et al., 2008). However, an aging population that remained uninfected has also been instrumental in changing the face of the community. With an

aging population also comes the need to provide safe and affordable housing as well as an increased need for social and health services that can address the specific needs the city's aging gay residents.

Other changes that have profoundly affected the gay community over the past several decades are domestic issues that have forever left their mark on a once illegal and highly stigmatized group of people. Two of the more significant issues are gay marriage and the population explosion of gay families with children. When HIV was beginning to take its toll on gay men, it was inconceivable that the community would be within grasp of legally recognized marriages before the epidemic would be over. However, despite the recent setback in the California election, the legality of gay marriage is an inevitable certainty. Likewise, the presence of children within the gay community has shifted from a rare to a rather commonplace occurrence (Power et al., 2010). It could be speculated that these changes are a life-affirming reaction to the death and devastation that HIV brought. It is also possible that these changes would have occurred more quickly after Stonewall had HIV not interrupted the trajectory of the newly liberated community.

However, not all that has transpired is a result of the mainstreaming of the community. The activism that was brought about by organizations such as Act-Up, which was created specifically to fight AIDS, lead to the birth of other groups that championed a new form of gender identity politics. Foremost in this area was Queer Nation that gave rise to a different kind of liberation for a younger generation (Zimmerman, 2007). Queer Nation opened the door that allowed a transformation of the gay community into the more inclusive queer community. This allowed people who didn't necessarily identify as strictly gay or lesbian to identify as queer. Included within this identity were bisexual and

transgender persons.

Transgenders, in particular, have become a much more visible component of the gay community since the HIV epidemic began. Whereas it could be argued that transwomen were responsible for fighting back against the forces of oppression at the Stonewall bar (Katz, 1985), they have been traditionally ostracized by the larger gay community. Drag queens have always been a part of the gay bar culture, but that is not the same as the acceptance of truly transgendered people in the everyday world of the workplace outside of nighttime entertainment. The past 20 years has seen attempts within some segments of the gay community to be more inclusive of transgenders. This has been in the form of transgender outreach at various gay religious and social organizations, transgender inclusion at San Francisco's annual Gay Parade, and even the addition of the T in the LGBT acronym (McMillan, 2007). That is not to say that all gay people have completely accepted transgenders as legitimate members of their community. Unfortunately, transphobia exists within the gay community as well as the larger society (Lombardi, 2009).

The above changes have all contributed to a gay community that is very different today than when HIV first appeared. This dissertation, Sexual Identity, Behavior, and Risk Among FTM Transgender Persons, presents background material and the results of a study that examined this population that has become a part of the fabric of the gay community.

The purpose of this study was to understand and describe the risks for HIV infection for FTM transgender persons who completed transition and were taking testosterone. HIV risk was defined as sexual and drug using behavior that put the

participant at a recognized risk for the acquisition of HIV. This study used data from interviews with the 17 participants. The data were analyzed using the methods of interpretive phenomenology. The overall research question for the study was; “What is the nature of sexual identity and related risk behavior among FTM transgender persons who are taking testosterone”?

The specific aims, or lines of inquiry, of the study were:

1. To describe and understand the variability in sexual orientation and behavior among FTM before and after transition and testosterone use.

2. To identify risk and understand how an FTM person’s situatedness within the gay community affects HIV risk behavior.

The papers presented here examine recent adaptations by the gay community to the ongoing HIV epidemic. Transgenders, specifically FTM, are then discussed with regard to how their newfound position within the gay community can impact HIV and STD risk.

The first paper presents a review of recent research regarding HIV risks and attitudes among MSM and reports on several trends that have repeatedly emerged from the literature. Phenomena such as safe sex fatigue, treatment optimism, and serosorting have recently become common among MSM communities and present a challenge for all who work in HIV prevention. Suggestions are made regarding implications for nursing and areas for future research. It is important to present this information as essentially a background regarding many of the current attitudes and practices that are prevalent in the gay community. These attitudes comprise the environment that all people who newly enter into the gay community must confront. They need to determine how to navigate the

world of gay sexuality and how they will negotiate their own safety.

Against this background, the next papers examine gender and the population of female-to-male (FTM) transgenders, or transmen. This group of people came to my attention through my clinical practice as an NP at San Francisco's STD clinic. Besides diagnosing and treating STDs, one of the most important aspects of being a clinician there is to identify those individuals who are at high risk for the acquisition of HIV. It was found that transmen were becoming more frequent patients at the clinic and that many identified as gay men and had gay men as sex partners. This meant that, because they were situated within the gay community, these transmen had, seemingly, the same, or similar, risks as the rest of the gay community.

A review of the literature found that much research had been done with transwomen and one study even found the HIV prevalence among transwomen in San Francisco, at over 50%, to be the highest for any population in the city (Herbst et al., 2008). However, there was very little comparable research available concerning transmen and risk. The few studies that were done found a very low HIV prevalence of about 2% (Clements-Nolle, Marx, Guzman, & Katz, 2001). This could certainly be due to under reporting since many transmen go stealth, or undercover, and never disclose their transgender status to the clinics where they get their care. It is possible that older studies have not yet caught up with the fairly recent phenomenon of transmen living within the gay community. It could also be that transmen have a lower prevalence due to certain protective practices. Sevelius stated that this might be the case with regard to online status disclosure that she saw among transmen (Sevelius, 2009). Regardless, more research was necessary to more fully understand how transmen came to identify as gay

men and how they negotiated the HIV and STD risks of a gay community that was now experiencing safe sex fatigue, treatment optimism, and trying to avoid infection through serosorting.

Before beginning the actual research with the FTM population it was necessary to have an understanding of my own feeling regarding the gender binary and gender variance. Prior to engaging in a serious research project with a transgender population, I needed to conduct my own exploration relevant to whether or not the gender binary was a valid universal or how those individuals who somehow manifested gender variance fit within that binary. Therefore, the second paper is a review of what is known and what is not known about the development of sexual differentiation and gender identity. It was clear from the pilot work with transmen that many felt that they were male from the time they were aware that gender existed. The paper examines the ways in which the brain and the formation of gender identity is influenced by the process of sexual differentiation. It is clear that much is still unknown. The paper then looks at a variety of intersex conditions and their etiology and how the different causes can result in very different outcomes. Of note is the theory, promulgated by John Money, which stated that a child could have its sex changed up to the age of two and one half years without any adverse consequences. This clearly placed socialization as more important than biological processes in the development of gender identity. This was the theory that guided much of the surgery performed on intersex children and it contradicted any idea that the brain is sexed in a similar manner to the body.

The third paper describes the results of the first line of inquiry from the study, to describe and understand the variability in sexual orientation and behavior among FTM

before and after transition and testosterone use. The nature of sexual orientation among the 17 participants of the study is presented. A common trajectory of transition is explained as well as a description of four distinct patterns of sexual orientation among the participants, including a group who indicated a shift in sexual attraction from a lifelong attraction to women to an attraction for men. This is contrary to much of the research with transgenders that found that sexual orientation was immutable. These findings also challenge the psychiatric literature that has stated that there were two distinct types of transgender: a homosexual subtype and a nonhomosexual subtype.

The last paper presents the results of the second line of inquiry of the study, to identify risk and understand how an FTM person's situatedness within the gay community affects HIV risk behavior. The HIV risk found among transmen is presented along with a description of the experience of being situated in the gay community and how that impacted risk. In some ways the risk of being a gay transman were similar to those of any man entering the gay community. However, there were also aspects of risk that were specific to the situation of transmen within the gay community. These included the fact that for many transmen, the gay community presented an unfamiliar situation that they were not prepared for. Also there were dynamics of acceptance and rejection between trans and nontrans men. Several incorrect assumptions regarding transmen and risk are discussed. Other aspects of risk discussed include the impact of testosterone, the resulting changed bodies, and finally sex work.

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Safe Sex Fatigue, Treatment Optimism, and Serosorting: New Challenges to HIV Prevention Among Men Who Have Sex With Men

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As the HIV epidemic enters its 3rd decade, it remains a major public health problem. The United States continues to be affected by HIV. Certain vulnerable populations, especially men who have sex with men (MSM) of all ethnicities and African Americans of all sexual orientations are disproportionately affected (Crosby, Holtgrave, Stall, Peterson, & Shouse, 2007).

Literature Review

HIV was first identified in the United States among MSM in the early 1980s. Community response and prevention efforts helped to change behaviors and decrease infection rates among MSM (Koblin et al., 2003). However, in the last 10 years HIV infection rates among MSM have shown a significant increase (Buchbinder, 2007). In many ways, syphilis served as a marker for changes that were occurring among MSM. Prior to HIV, syphilis rates in the country, and in San Francisco in particular, were high. At its height, 2000 cases of syphilis were reported in San Francisco in 1979, primarily among MSM (Wong, Chaw, Kent, & Klausner, 2005). The advent of HIV resulted in community-wide behavior change that was made evident by a dramatic decrease in syphilis and other sexually transmitted disease (STD) rates. By the mid 1990s, the syphilis rates were so low that STD experts around the country were prepared to state that syphilis could be successfully eliminated from the United States. By the end of that decade, however, syphilis began to reemerge and was highly associated with rising HIV rates among MSM. HIV prevention researchers began investigating factors that were associated with this trend. Much research has been devoted to examining changes that have taken place in the MSM community to explain the phenomenon of rising HIV rates (Buchbinder, 2007).

A new vocabulary has been developed to describe the recent trend of rising infection rates. Three new terms have appeared in the recent studies involving MSM in the United States and Western Europe: safe sex fatigue, treatment optimism, and serosorting (Osmond, Pollack, Paul, & Catania, 2007; D. G. Ostrow et al., 2008; Schwarcz, Scheer et al., 2007). The following literature review will examine these concepts as well as several other variables that have been associated with current HIV risks among MSM.

Safe Sex Fatigue

As an explanation of rising STD and HIV infection rates, safe sex fatigue has been the focus of a number of studies (D. G. Ostrow et al., 2008; Schwarcz, Scheer et al., 2007; Stolte et al., 2006). This concept was defined by the statement "I find it difficult to maintain sexual safety" in one study that used a 20-item attitude survey to compare attitudes and behaviors of 263 HIV-infected MSM with 238 uninfected MSM in multiple cities (D. G. Ostrow et al., 2008). Findings revealed that an increased percentage of unprotected anal sexual partners among HIV-infected men was associated with a decreased concern about HIV and an increase in safe sex fatigue. Among the uninfected men, this increase was associated with safe sex fatigue alone. However, many of these men were reported to be in monogamous relationships with other uninfected men. The HIV-infected men did not report similar monogamous or same HIV status relationships.

Another study also looked specifically at safe sex fatigue as a mediator for rectal gonorrhea among MSM in Amsterdam (Stolte et al., 2006). Given increasing rates of rectal gonorrhea, these researchers surveyed 1568 MSM patients at the Amsterdam STD clinic. Attitudes on the survey were compared to gonorrhea rates and the HIV status of

the men. The HIV-infected men in this study had the most risk for gonorrhea, which was associated with safe sex fatigue more than the other variables examined, including treatment optimism. Among uninfected men, those who engaged in unprotected sex with a steady partner had higher gonorrhea rates than those who reported consistent condom use, suggesting that the steady partnership was not necessarily protective against STDs.

Treatment Optimism

While safe sex fatigue was used to describe the inability of individuals to maintain safe sex practices, the term treatment optimism, or antiretroviral therapy (ART) optimism has been employed to describe a social phenomenon that can explain the reason for abandoning safe sex practices. A recent study using telephone surveys in San Francisco sought to determine HIV prevalence among a convenience sample of 1976 MSM as well as what they called the "novel" cofactors associated with the current increases in HIV rates. The authors defined treatment optimism as "feeling less concerned about acquiring HIV because of medications that can reduce HIV-related mortality and morbidity" (Schwarcz, Scheer et al., 2007, p. 1067). They found a 25.2% HIV prevalence rate among participants. Risk behaviors of unprotected sex and drug use that facilitated the sex were associated with treatment optimism among both HIV-infected and uninfected men.

An earlier study examined treatment optimism as a variable for increased risk among both HIV-infected and uninfected men (D. E. Ostrow et al., 2002). The study, which included 329 HIV-infected and 218 uninfected MSM, found that ART-related attitudes were a significant determinant for high-risk sexual activity. Using a 5-point Likert scale, the authors found that a reduced concern about HIV, the perception that HIV

was not as much of a threat as it was prior to effective treatments, and the belief that ART decreased concern about transmission, were associated with increased incidence of unprotected sex. The study looked at self-reported unprotected anal sex in the previous 6 months. Of those men who reported any anal sex, more than 50% of the sample reported that it was unprotected. This was seen in both uninfected and HIV-infected men and was associated with reduced concern about HIV infection due to the advent of effective ART. The authors of this study believed that treatment optimism was emerging as a widespread phenomenon among MSM in the United States and called for a tailoring of HIV prevention efforts based on this increasing attitude (D. E. Ostrow et al., 2002).

In order to plan appropriate interventions, it is important to understand which specific beliefs lead to treatment optimism and increased risk. One group of researchers surveyed MSM at gay events in Atlanta: 498 men were surveyed in 1997, 448 in 2005, and 503 in 2007 (Kalichman et al., 2007). Treatment optimism was measured by responses to questions pertaining to risk perceptions regarding unprotected anal sex with an HIV-infected individual on medication who had an undetectable viral load. A 5-point scale measured attitudes ranging from *very low risk* to *very high risk*. Results demonstrated increased belief over time that HIV treatment reduced transmission risk because of undetectable viral load, and this belief was associated with concomitant increases in unprotected anal sex.

While the above study looked specifically at beliefs about the significance of viral load as related to risk within a community of MSM in Atlanta, very little has been published about beliefs concerning the risk of acquiring a drug-resistant virus. Reports reveal that drug-resistant strains of HIV can be transmitted and that the prevalence of

resistant virus may be increasing (Leigh Brown et al., 2003), but how this information impacts treatment optimism and risk behavior in the uninfected is less well documented. A study that examined the beliefs of 456 HIV-infected MSM in San Francisco and New York asked specifically if the participants thought that unprotected sex between two HIV-infected men could result in infection with drug-resistant virus (Remien, Halkitis, O'Leary, Wolitski, & Gomez, 2005). Very few of the men in the study reported engaging in unprotected sex, and those who did were less likely to believe that unprotected sex carried a risk for re-infection with drug-resistant virus. Because of the real risk of being either initially infected or possibly re-infected with resistant virus, beliefs and attitudes regarding these issues among MSM, and how those attitudes can effect risk behavior, need to be explored in future studies.

Serosorting

Besides comparing how treatment optimism can lead to safe sex fatigue, much research has also focused on new strategies adopted by MSM to deal with HIV risk. Serosorting, the practice of choosing to have unprotected sex with a partner of the same HIV status as oneself, has been one of the more widely researched strategies.

As a result of reports of increased HIV risk behaviors subsequent to the widespread use of ART, one study examined changes in HIV prevalence and behaviors among MSM in San Francisco between the years 1997 and 2002 (Osmond et al., 2007). Random telephone surveys were conducted with 915 MSM in 1997 and 879 MSM in 2002. Of interest was the fact that HIV prevalence increased in the sample population from 19.6% to 26.8% and so did reported sexual risk. The average number of partners increased as well as the amount of unprotected sex with a partner of different or unknown

HIV status, but the largest increase was seen among men who reported that they engaged in serosorting. This was seen for both HIV-infected and uninfected men. While the authors reported an increase of this practice, they did not state whether they believed this to be an effective or ineffective strategy.

In order to examine the question of efficacy of serosorting, another study in San Francisco looked at trends in sexual behavior and incidence of STDs, including HIV, to assess whether serosorting was contributing to a stabilization of transmission of HIV (Truong et al., 2006). The researchers used epidemiological data from the San Francisco Department of Public Health STD and HIV prevalence. They used behavioral data from a number of community prevention programs and HIV testing sites. The authors stated they believed that HIV incidence among MSM appeared to have stabilized at a plateau after a number of years of increasing rates. They also stated that the strategy of serosorting may have contributed to that stabilization. They noted, however, that both HIV and STD rates remained very high and that serosorting was an imperfect means of HIV prevention given that the status of a person's partner is often not what it is purported to be. In many ways this study offered conjecture without any clear evidence to substantiate whether serosorting had affected HIV transmission rates. The actual number of subjects was not provided because the data were based on a wide array of epidemiological reports. This pointed to a need for more studies to examine the efficacy of serosorting in a large longitudinal study.

Substance Abuse

Safe sex fatigue, treatment optimism, and serosorting can all be seen as recently identified variables associated with HIV risk among MSM. Substance abuse, especially

the use of methamphetamines, has repeatedly been cited in studies as a determinant of high-risk behavior (Colfax et al., 2005; Drumright et al., 2007; Morin et al., 2007; Schwarcz, Scheer et al., 2007). A recent study by Drumright et al. (2007) assessed the association of substance abuse with unprotected anal sex before and after HIV seroconversions among recently infected MSM. A survey was conducted with a convenience sample of 207 MSM referred from clinics in San Diego and Los Angeles. Prior to diagnosis, unprotected sex was associated with use of methamphetamine alone and in combination with other drugs. After diagnosis, unprotected sex was associated with drugs other than methamphetamines. Unfortunately, in this small sample no information was given as to why this change occurred.

Other researchers have noted the connection between substance abuse and risk. In a previously mentioned survey of 1976 MSM in San Francisco (Schwarcz, Scheer et al., 2007), methamphetamine, especially when combined with Viagra, was indicated as a predictor for high risk behavior. Another recent study, looking at a younger MSM population, found that high rates of HIV among 16-to-24-year-old MSM was due, in part, to the interaction of street drugs and alcohol with mental health problems and exposure to violence (Mustanski, Garofalo, Herrick, & Donenberg, 2007). Also, several large randomized behavioral intervention trials with research components have reported a high association of methamphetamine use with sexual risk among MSM (Koblin et al., 2003; Koblin et al., 2006; D. G. Ostrow et al., 2008).

These studies and many others have documented the relationship between substance use, especially methamphetamines, and HIV risk. One study attempted to understand why the MSM community has been so closely associated with the use of

methamphetamines (Green & Halkitis, 2006). This was a grounded theory study that looked at the social context of methamphetamine use among 49 MSM in Manhattan. The authors discussed Manhattan's gay sexual subculture as a social environment with values of sexual sociality and sexual pleasure. They concluded that this subculture had formed an elective affinity with methamphetamine due to pharmacological effects that benefited its users through increased sexual performance, increased endurance, increased libido, diminished inhibition, and increased pain threshold. Since this was a qualitative study, the purpose was not to generalize these findings to a larger population, but rather to inform the research community about the phenomenon in question and to help define and revise future research questions. Examining the social context and the positive attributes of the use of a particular drug, especially if it is highly associated with HIV transmission, can also be of value in the development of intervention and prevention strategies (Green & Halkitis, 2006).

Racial Disparities

One salient and recurring point in the studies of MSM and HIV risk was the fact that HIV infection rates among African American MSM were disproportionately higher than for MSM of other ethnicities (Crosby et al., 2007; Schwarcz, Scheer et al., 2007). Given this situation, one recently published study compared the differences between HIV risk behaviors among African American and White MSM in Atlanta, Georgia (Crosby et al., 2007). A survey was conducted with 540 White and 306 African American participants. The results of the study appeared to belie the epidemiological facts. No statistical differences were found between Whites and African Americans with regard to unprotected sex with serodiscordant partners. Serodiscordance was determined by asking

the participants what they knew, or believed they knew, about the HIV status of their partners. Among uninfected men it was found that Whites engaged in higher risk activity than African Americans. The authors felt that these results pointed to the need for further study of the African American MSM population and risk behaviors.

A large multiple-city study recruited 4295 uninfected MSM and assessed risk factors for HIV infection (Koblin et al., 2006). The researchers found that despite the fact that African American men in the study were disproportionately more likely to be infected with HIV, the reported risk behaviors of the African Americans were not significantly different from other ethnicities.

Studies examining MSM communities have often included limited numbers of African American MSM (Koblin et al., 2003; Koblin et al., 2006; Schwarcz, Scheer et al., 2007) and it is possible that the survey methods, often via telephone, and convenience sampling at identified gay venues, have missed a representative proportion of this high-risk population. As a result, the literature may not be revealing the true picture of what is happening among African American MSM regarding specific risk behaviors, their determinants, and the social context.

Gay Community Integration

In this section, which discusses aspects of gay community integration, it is important to make the distinction between MSM and gay men. While MSM is a strictly behavioral term, gay is a term of self-description and often is used to refer to people who have been through the process of "coming out." Clearly, many people who are MSM would not be considered, or consider themselves, gay. Interestingly, two studies found that integration in the gay community was associated with a higher risk of being infected

with HIV (Fergus, Lewis, Darbes, & Butterfield, 2005; Martin, Pryce, & Leeper, 2005). Community involvement is usually seen as a source of social support, so these results would appear to be contradictory. However community integration associated with being infected with HIV was defined as going to gay bars and attending gay clubs. Other types of community integration such as sports or political groups were found to have no association with HIV status. One problem with this conclusion is that it is difficult to differentiate cause from effect. Perhaps having HIV draws people into a gay environment where they may feel less social stigma and more support.

One brief report made the distinction between general social support and HIV-specific social support as it related to sexual risk behavior among gay couples (Darbes & Lewis, 2005). The authors found that couples who reported greater levels of HIV-specific social support also reported less HIV risk behavior. HIV risk behavior was assessed according to a measure developed by the Center for AIDS Prevention Studies at the University of California, San Francisco. This measure examined such variables as monogamy, HIV status, anal sex with primary and secondary partners within the previous 30 days, and condom use. Even though the risk was well defined, the components of general versus HIV-specific social support were not made explicit. It was not stated if issues related to homophobia, validation of gay identity, and the value of gay partnership were addressed by either type of social support or how they were addressed.

It has been posited that, with regard to the relationship between gay community involvement and risk behavior, the key may not be the involvement itself, but the specific benefits of that involvement. In a paper that provided a conceptual framework for the protective effects of community involvement, Ramirez-Valles (2002) discussed

homophobia, poverty, and racism as factors associated with increased sexual risk, especially for gay men of color. It was suggested that involvement in gay community-based organizations could offer protection to buffer against these factors. If an organization was HIV-related, it was hypothesized that it could reduce HIV risk behavior among those involved in four ways: (a) by increasing peer norms regarding safer sex, (b) by increasing self-efficacy regarding condom use, (c) by increasing positive aspects of gay identity, and (d) by decreasing social alienation (Ramirez-Valles, 2002). The paper emphasized the need to examine the specifics of gay community involvement and this is certainly an area needing more detailed research. There is also a need to consider those MSM who don't identify as being part of the gay community as they may not be receiving the kind of HIV prevention and support that is available to those who have a more self-accepting gay identity.

The State of Knowledge

The preceding literature review presents a number of points regarding the current knowledge of HIV risk among MSM in general. When the epidemic first began in the United States in the mid 1980s, prevention efforts from within the MSM population resulted in decreased rates of new infections. At that time treatment options were few and survival after a diagnosis of AIDS was approximately 6 months (Koblin et al., 2006). In the late 1990s, with the advent of new medications such as protease inhibitors, a new era of highly effective ART began. The benefits were seen immediately but the social changes that resulted from improved treatment took several years to emerge (D. G. Ostrow et al., 2008).

In order to understand the social dynamics of what contributed to this reversal in HIV transmission trends, much research has focused on factors related to recent HIV seroconversions among MSM. Changing attitudes and practices among MSM, especially in urban centers in the United States and Western Europe, could be seen as a shift that was set in motion by a new-found optimism related to the visible effects of the medications (D. E. Ostrow et al., 2002; D. G. Ostrow et al., 2008; Schwarcz, Scheer et al., 2007). Researchers found that other processes were taking place within the context of treatment optimism. New concepts such as safe sex fatigue and serosorting emerged in the literature as variables to explain high-risk behaviors (Schwarcz, Scheer et al., 2007; Stolte et al., 2006). It was also noted that substance abuse, especially of methamphetamines used alone and with Viagra, continued to be a major contributing factor to HIV risk and transmission among MSM (Buchbinder, 2007; Drumright et al., 2007; Green & Halkitis, 2006; Koblin et al., 2006; Morin et al., 2007; Schwarcz, Scheer et al., 2007; Schwarcz, Weinstock et al., 2007).

African American MSM, a subgroup within the larger MSM population, have been reported to have unique vulnerability to HIV (Crosby et al., 2007; Dolcini, Catania, Stall, & Pollack, 2003). Even though HIV rates among African American men are much higher than for other ethnic groups, the research has not managed to document differences in attitudes or behaviors that could account for such striking disparities (Crosby et al., 2007; Koblin et al., 2003; Koblin et al., 2006).

Implications for Nursing and Future Research

Any nurse who works with MSM clientele, whether in-patient or out-patient, needs to be aware of the possible attitudes regarding HIV risk and prevention in these

patients. Too often we assume that our uninfected patients are following all the current guidelines for safe sex and they don't have any ambivalence regarding HIV prevention. Even if the patient doesn't have a problem with methamphetamines, it is possible that safe sex fatigue, triggered by treatment optimism, and perhaps accompanied by a less than ideal method of serosorting, undermines prevention efforts that have been effective in the past. Knowledge about recent trends can help nurses anticipate difficulties that patients may have in maintaining safe sex practices. With many patients, it may be beneficial to directly ask if these concepts have affected their efforts to remain uninfected. Patients might be concerned by their own lapses in safe sex practices. It can be helpful to provide the patient with names for these phenomena. Realizing that he is exhibiting safe sex fatigue may help a patient to see that he is not alone, that others have also experienced this problem and that it can be overcome through education and counseling. Beliefs that lead to treatment optimism could be modified by patient education that acknowledges while a person who is taking ART with an undetectable viral load is theoretically much less likely to transmit HIV than a person with a detectable viral load, there is no certainty that the viral load in the blood correlates with the viral load in the semen, which is more significant for sexual transmission. Additionally, certain conditions, such as the presence of an STD, can cause a spike in viral load and increase the likelihood of HIV transmission (Wong et al., 2005). Beliefs about the risk of infection with drug-resistant virus and the implications of infection should be assessed and addressed.

Given the current state of HIV prevention within the MSM community, a number of topics would be appropriate for future research. One question that may prove essential

for prevention efforts is how the meaning of HIV has changed for MSM over time. It also would be of value to examine if there are differences between Whites and other ethnic groups, especially African Americans, with regard to HIV risks and perceptions. Despite the higher HIV prevalence, current research hasn't demonstrated differences in risk behaviors. Study sampling methods may be flawed, the researchers may lack cultural sensitivity, or a lack of trust may exist with researchers, and these are obstacles to obtaining valid findings. The possible benefits or risks of gay community integration need to be clearly defined and examined, especially concerning differences among various racial and ethnic groups. Men who have sex with both men and women provide a vector of transmission between MSM and the larger heterosexual population, yet we have very little data on the scope and nature of this phenomenon. It is also important to understand the unique risk factors for other subgroups often viewed as part of the gay community such as transgender populations, both male-to-female and female-to-male. Most importantly, we need to understand the kinds of effective prevention efforts that could be devised for all of these groups.

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When Gender Is Uncertain: Interventions With Various Intersex Conditions

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Nurse practitioners and other advanced practice nurses are seldom consulted regarding the decisions pertaining to sexual assignment for individuals born with ambiguous genitalia. However, throughout their lifespan, these individuals will be patients of NPs. Regardless of whether one practices in an STD clinic or general medicine, it is essential that NPs have a basic understanding of the variety of conditions that can lead to the birth of an intersex child and what to expect later in life, especially during puberty. It is also important to understand the theoretical beliefs that have guided the decisions concerning options for medical interventions with these children and adults. This paper will first review what is known, and likewise unknown, about the process of sexual differentiation. This will be followed by a description of a variety of intersex conditions and their etiology. The paper will conclude with a discussion regarding theories of gender identity and how they can influence medical decisions of sexual assignment. The purpose of this paper is not to guide NPs through a decision making process for sex assignment, but to provide an understanding of the variety of causes of intersex conditions and possible outcomes. This will enable an appreciation of the complexity of the task of determining and changing gender when the status may not be evident.

The Process of Sexual Differentiation

The process of sexual differentiation is determined initially by the chromosomal makeup of the fetus. Human beings have 23 pairs of chromosomes, one of each pair from each parent, and the genes are located on these chromosomes. The autosomes are the first 22 pairs of chromosomes. The last pair consists of the sex chromosomes of which there is an X chromosome and a Y chromosome (National Institute of Health, 2008). The XX

pattern programs for a biological female and the XY pattern programs for a biological male. In many ways female sex is the default condition and it is the presence of the SRY gene on the Y chromosome, also known as the testis-determining factor (TDF), that brings about the development of the testes and a subsequent surge of biological changes that result in male anatomy. It is the hormonal products of the testes, or the androgens, that direct the male differentiation of the genitals and brain (Speroff, Glass, & Kase, 1989). The most important androgen is testosterone, though there are others such as dehydroepiandrosterone (DHEA) and androsterone. Anti-mullerian hormone (AMH) secreted by the testes causes the regression of internal female genital structures.

By the seventh or eighth week of gestation the testes begin to secrete the androgens. This process is regulated by human chorionic gonadotropin (HCG) from the placenta until about the fifteenth week of gestation when gonadotropin from the fetal pituitary gland assumes control. The action of the fetal pituitary is in turn regulated by the fetal hypothalamus. The enzyme 5 alpha-reductase plays the important role of converting testosterone into 5 alpha-dihydrotestosterone (DHT) that has three to seven times the biopotency of testosterone (Pradidarcheep & Showpittapornchai, 2009). DHT is essential for the development of internal and external male genital structures. By the end of gestation, the secretion of gonadotropin has decreased. The androgen levels in the male fetus are elevated between weeks 8-24 of gestation with the peak levels occurring between weeks 14-16. Interestingly, the penis does not grow to a size larger than the clitoris until the third trimester when testosterone levels are decreasing. After birth, levels of testosterone in males increase to peak between months 1-3 and then levels fall by months 4-6 until the onset of puberty. Testosterone can be converted to estrogen via the

enzyme aromatase through the process known as aromatization. Estrogens are important for the developing male body especially with regard to skeletal maturation during puberty (Pradidarcheep & Showpittapornchai, 2009).

In the absence of testosterone, the fetus will develop as a biological female regardless of its genetic or chromosomal makeup (Kolon, 2008). In females the ovary remains fairly inactive until after birth. At that point the ovaries secrete estradiol for the first 6-12 months. After the first year of life there is a sharp reduction in gonadal activity until puberty. The times in human development that hormones could potentially influence biological sexual differentiation are therefore during 8-24 weeks of gestation, within the first 6-12 months after birth, and again at puberty.

Although a clear-cut effect of hormones on genital development is generally accepted, there is less agreement regarding the effect of hormones on sexual differentiation within the brain. Animal studies have demonstrated that the presence of testosterone or DHT leads to the activation of androgen receptors that result in the masculinization of the brain structure (Byne, 2006). These studies also suggest that male and female animals not only have different hormonal requirements for sexual differentiation but that the differentiation of the genitals and brain can occur at different periods. The occurrence of sexual differentiation of the brain has been demonstrated in animals with regard to sexual behaviors such as copulatory positioning, as well as non-sexual behavior such as territoriality, aggressiveness, and caring for offspring. It has also been stated by medical researchers that, as with the genitals, testosterone allows for the male brain and the lack of testosterone results in the default, or the female brain This has lead many researchers to conclude that the same hormonal mechanisms that determine

the sexual differentiation of the genitals also lead to the wiring, or sexual differentiation, of the brain (Pradidarcheep & Showpittapornchai, 2009).

How hormones work in the human brain to cause sexual differentiation, or what sexual differentiation in the human brain really is, are currently unclear and certainly ethical considerations prevent extensive research. Some studies, such as the well publicized work of Simon LeVay (LeVay, 1991) have tried to demonstrate how differences in the size of the hypothalamus could explain variations in gender identity or sexual orientation. LeVay stated that the anterior portion of the hypothalamus was larger in heterosexual males than in women and that in homosexual men the sexual differentiation of the hypothalamus was in a female direction. However, subsequent studies failed to confirm his findings (Pradidarcheep & Showpittapornchai, 2009).

Medical researchers in the area of sexual differentiation, gender role, and gender identity, such as John Money, theorized in the 1950s that the environment and the various conditions under which a child was raised were more influential than the biological components for determining a person's gender identification (Mazur, 2005). In other words, they favored the nurture side of the equation over nature. In the case of children born with ambiguous genitalia, it was thus believed that choosing the genital type that would be easier to construct and then assigning the patient to that gender, with parental reinforcement, was all that was required to prevent a conflict between gender identity and the assigned sex from occurring. This meant that regardless of other biological markers of sex, most intersexed children were assigned to the female sex because vaginoplasty was more surgically feasible than phalloplasty (Speroff et al., 1989).

The theoretical assumption behind this approach to gender is that individuals are born gender neutral and that seeing and possessing the genitals of a specific sex will result in gender identification aligning with that sex even if those genitals were surgically constructed. One case, well documented in the literature, can serve to dispute this notion (Diamond & Sigmundson, 1997). In the 1950s in the US, a pair of XY male twins was born. At the age of 8 months one of the twins had his penis ablated during a phimosis procedure. The decision of the medical team was to surgically construct female genitalia and raise the genetic male, John, as a female, Joan. Initial reports recounted the great success of this approach. They also helped to support the theory that gender identification was not something biologically ingrained within the person but could be manipulated by environmental factors. At age 12 Joan was placed on estrogen, which allowed for the development of breasts. This did not help to ameliorate a troubling conflict between gender identity and the reconstructed biological sex that Joan had been experiencing, and at age 14, after finding out the truth of his condition from his father, Joan began living as a male. He was given testosterone and had a mastectomy at age 14 and phalloplasty two years later. He married at age 25 but unfortunately committed suicide in 2004 (Byne, 2006).

Many current theories favor the notion that intrauterine hormones may have a greater effect on the sexual differentiating aspects of the fetal brain and gender identification than previously believed. However, the method by which these processes may work and how the crucial aspect of timing could influence the outcome are unknown. One study that explored similar territory to LeVay examined differences in the size of the bed nucleus of the stria terminalis (BST) in the brain (Zhou, Hofman, Gooren,

& Swaab, 1995). The research hypothesis was that sexual differentiation in the brain of male-to-female transgenders diverged from the process that lead to sexual differentiation of the rest of the body. The belief was that gender identity developed as a result of hormonal action on the fetal brain and that this could cause a gender identity at odds with biological sex. The researchers recognized that transgenders could have sexual behavior that was oriented to either sex so they wanted to examine a brain structure that was sexually dimorphic but not in any way influenced by sexual orientation. Animal models contained the only data regarding such sexual dimorphism but determining animal gender identification can be problematic. BST was chosen based on previous studies that found that it plays an important role in rodent sexual behavior and also contains both estrogen and androgen receptors. It had also been previously reported that certain parts of the BST were more than twice the size in men than in women. The central portion of the BST (BSTc) was measured postmortem in 42 subjects. They consisted of six MTF, 12 heterosexual men, nine homosexual men, and 11 heterosexual women. The researchers acknowledged that the sexual orientation of the subjects can only be presumed and never truly known. It was found that the BSTc in the women and MTF was roughly 50% smaller than in the heterosexual and homosexual men. This difference was determined to be unrelated to any adult hormonal influence. The researchers concluded that the study supported the hypothesis that variations in normative gender identification may be the result of an altered interaction between sex hormones and the developing brain.

The above study demonstrates the difficulties inherent in conducting research concerning neurobiology, human sexual behavior, and gender identification. Definitive results regarding brain structures are often only available upon autopsy. The true nature

of a subject's sexual behavior or gender identification may never be known. Also, information gained from animal studies doesn't necessarily translate directly to an understanding of human biology or behavior. Despite these problems, such studies as the above mentioned and case studies of a variety of conditions that result in non-normative gender presentations can help to move theories of gender and sex closer to an understanding of how the interplay of biology and social factors can influence gender identity.

Biological Conditions Affecting Gender Presentation and Identification

Much of the theorizing regarding gender identity has been based on information derived from the study of various conditions known to result in non-normative gender presentation and observations of the resulting variations in gender identification. The following discussion will focus on several of the well-documented developmental, genetic, chromosomal, and hormonal syndromes that can impact biological sexual presentation. This can foster an appreciation of the relationship between biology and gender identity and the complex processes necessary to produce a harmonious convergence of all the factors involved or how dissonance can result.

Cloacal exstrophy and Penile agenesis

Both cloacal exstrophy and penile agenesis are conditions that have no genetic or hormonal component but are disorders of embryonic development that can result in an intersex condition where gender assignment and surgery are not uncommon. Cloacal exstrophy involves the genitals and intestinal tract of both genetic males and females. The condition is extremely rare and prior to surgical advances in the 1960s, it was usually fatal (Zucker, 2002). In males the genitals are often absent or ambiguous though

testicular function is often present. As a result, they are often castrated, reassigned as females, and given estrogen at puberty. Limited studies and case reports have demonstrated that many such individuals who were reassigned to female later report a gender identity as male and seek reconstruction surgery (Byne, 2006).

In penile agenesis the penis fails to form although the scrotum and functioning testes are present. There are over 20 cases reported in the literature but follow-up is available for very few. There were four cases that reportedly were assigned to be males and all have retained that gender identity. Of the more than twelve cases that were surgically assigned as female, follow-up is available for only two. One was reported at age 13 to be content with her gender assignment. The other was living as a female at age 15 but was living as a man at age 27 (Zucker, 1999).

Chromosomal conditions; Turner syndrome, Klinefelter syndrome

Turner and Klinefelter syndromes are both chromosomal alterations that can result in discordance between sex and gender identity. Turner syndrome is the result of a single X chromosome instead of the usual XX or XY. A single Y is not compatible with life (Ghosh & Walker, 2006). Female hormones in utero are unaffected and individuals are born with external female genitalia but the ovaries may undergo abnormal development. Infertility is common and exogenous estrogen is often used at puberty to bring about secondary sex characteristics. In many cases a person may exhibit short stature and structural changes in the neck and chest. It has been reported that many women with Turner syndrome experience some confusion regarding gender identity (Ghosh & Walker, 2006).

Klinefelter syndrome is diagnosed when an individual has a XXY chromosome pattern. Due to the presence of the Y chromosome, typical male genital development occurs. With the onset of puberty, gynecomastia occurs along with very low levels of testosterone. The physical appearance tends to be tall and thin and it is common for people with Klinefelter syndrome to be infertile. The syndrome has also been associated with emotional disorders and there has been speculation among medical researchers that there may be an association with difficulties regarding gender identification though this has not been adequately studied (Ghosh & Walker, 2006).

Congenital adrenal hyperplasia

Both genetic males and females can develop congenital adrenal hyperplasia, though when it occurs in males no genital abnormalities are seen. Among chromosomal females, this condition accounts for the majority of genital ambiguities (Kolon, 2008). The approximate incidence is one per 14,200 births (Ghosh & Walker, 2006). The condition is the result of a defect in an enzyme that is involved in the pathway of cortisol production by the fetal adrenal gland. As a consequence adrenal androgens are overproduced and this fetal exposure causes a masculinization of the female genitalia. This can range from unambiguous clitoral enlargement to cases of a male appearance with a penile urethra. Many such individuals are assigned to the male sex at birth. In some cases the condition is discovered because of an associated salt-losing nephropathy. If the condition is recognized at birth, the infant can be given cortisol replacement therapy that can prevent further masculinization and allow for ovarian function with fertility at the onset of puberty.

The exposure of the fetal brain to androgenic hormones raises questions of gender identity among those XX chromosome individuals who were raised as either male or female. Studies among those who were raised as female have reported that the majority reported female gender identity with increased incidence of gender nonconformity, gender dysphoria, and gender ambivalence. Four cases were reported to have developed male gender identity that emerged in late adolescence despite having been raised as female (Meyer-Bahlburg et al., 1996). However, it was also reported that it was far less likely to obtain follow-up from those individuals who experienced any kind of gender dysphoria compared to those who reported none. Currently, congenital adrenal hyperplasia tends to be diagnosed fairly early in an infant's life. A review of the literature regarding adult follow-up with CAD children found that 263 who were raised as girls, 250, or 94.8%, had no reported gender dysphoria, whereas 13, 5.2% did. Of the 33 raised as males, 4, or 12.1%, reported dysphoria (Dessens, Slijper, & Drop, 2005).

Androgen insensitivity syndrome

Complete androgen insensitivity syndrome (AIS) represents a rather unique condition where a chromosomal male, XY, has what appear to be normal female external genitalia. The incidence is approximately one per 20,000 births (Ghosh & Walker, 2006). This is an X-linked condition caused by a variety of possible mutations in the androgen receptor gene (Kohler et al., 2005). Individuals develop functioning testes and thus produce testosterone but the body lacks any functioning androgen receptors to use the testosterone. Without the influence of testosterone, the body then operates in its usual default program and external female genitals are formed from fetal tissue. Even though the body cannot respond to androgens, it can still respond to Mullerian inhibitory

substance that results in the regression of internal female genital structures. The testosterone produced at puberty is converted into estrogen and female body fat distribution and breast development occur. These individuals do not menstruate and are infertile. The condition is often undetected unless the testes descend into the labia or inguinal area and become palpable.

AIS individuals, therefore, are XY males who, in the absence of functioning testosterone, have female-appearing genitals and are raised with a female gender role. The reported gender identity of all known cases has been female and there are no reports of any individuals with complete AIS expressing gender dysphoria or male gender identity (Fausto-Sterling, 2000). This situation provides a strong case for the argument that for male gender identity and the presumed male brain differentiation, testosterone must not only be present but must be capable of being used by the body and brain (Wilson, 2001).

It is also possible for individuals to possess partial androgen insensitivity (PAIS). In this condition there is incomplete resistance to androgens and the external genitalia is partially masculinized. The level of masculinization is dependant upon the degree of androgen resistance present. Assignment of sex at birth has been in accordance with the appearance of the genitals (Wilson, 2001). Several studies have followed small cohorts of individuals with partial androgen insensitivity that were assigned and reared as males or females. In these studies most of the subjects remained in their assigned sex at the time of follow-up. However, it was noted that some of those assigned to female sex exhibited gender inappropriate behavior and one subject requested gender reassignment to male at

age 30. There was no report of gender conflict or reassignment for those who were raised as male (Byne, 2006).

5 alpha-reductase deficiency

The deficiency of the enzyme 5 alpha-reductase results in the inability to convert testosterone into dihydrotestosterone (DHT). Individuals with this deficiency possess XY chromosomes and have testes that produce testosterone. However, since DHT is necessary for full normative masculinization of the genitals of the fetus, they present with a penis that resembles a clitoris or labioscrotal folds that appear to be female genitalia. Many individuals born with this condition have been assumed to be female and thus raised as such. Because testosterone, and not DHT, is essential for the changes at puberty, these individuals experience penis growth and other secondary sex characteristics at that time. It is unknown what the general prevalence of this deficiency is but interestingly, this condition has been studied in several villages in the Dominican Republic where the prevalence is quite high due to consanguineous marriages. One study of 18 individuals who were raised as females from birth found that at puberty 17 changed to a male gender role and presentation (Imperato-McGinley, Peterson, Gautier, & Sturla, 1979). This would appear to support the idea that hormonal influence may be more important for gender identity than the social influence of being raised as female. These assertions are certainly problematic but this situation provides more evidence to dispute Money's theory that the environment in which the child is raised is the most important factor for gender identity.

17 beta-hydroxysteroid dehydrogenase deficiency

The condition of 17 beta-hydroxysteroid dehydrogenase deficiency, a genetic mutation of unknown frequency (Wilson, 2001) is the lack of an enzyme involved in the synthesis of testosterone, which is therefore absent at the time of fetal differentiation of the external genitalia. Affected individuals possess XY chromosomes and have testes and internal male genital structures but also have external female genitalia. The deficiency of the enzyme can improve over time and many individuals eventually produce testosterone to within normal range by the time of puberty. Most individuals are given female assignment at birth and come to medical attention due to masculinization at puberty or failure to menstruate. Various reports indicate that many of those who were raised as females change gender identity to male at the time of puberty (Rosler, 2006; Wilson, 2001).

Micropenis

Micropenis is a medical condition which is defined as a penile length of equal or less than the 10^{th} percentile for age-related norms (Zucker, 1999). In order for a penis that is within the normal size range to form, androgens are necessary at two different stages. In the early fetal period androgens form the penis and scrotum from the precursor tissue, and then in later fetal life androgens are needed to increase the size beyond that of the clitoris. It is believed that XY individuals diagnosed with micropenis were lacking sufficient androgens during the second fetal period. There are 16 cases reported of individuals who were assigned to female sex at birth. Follow-up is only available for eight of them, and only one as an adult. All were reported to have retained a female gender identity at the time. Twenty-two individuals who were assigned to male gender

were available for follow-up and all reported to have maintained male gender identification (Byne, 2006).

Theory Behind The Practice

The preceding account of various conditions that can result in genital ambiguity, and thus sex assignment surgery that is contrary to the genetic sex programming of the individual, raises several issues regarding gender identity and the role of medicine when the determination of biological sex is questionable. One quite salient point is that medicine has been operating based on a theoretical position that is controversial, unproven, and is increasingly challenged from both inside and outside the medical profession. John Money concluded in the 1950s that the gender assignment at birth was the best predictor of gender role and identity in later life (Fausto-Sterling, 2000). Social and environmental factors were considered to be far more important that any innate genetic or hormonal influence; thus any genitals that might be problematic should be surgically "corrected" as soon as possible and as long as the child was reared in a genital-gender appropriate manner there would be very little likelihood of a conflict between the constructed biological sex and gender identity.

The question of the eventual gender identity of a child born intersex sheds some light on how much is simply not known. The reported cases indicating reassignment failures suggest that surgery and rearing alone are not enough to guarantee a gender identity that is congruent with the altered genitals. The limited reports available indicate that many of those individuals with penile agenesis, partial androgen insensitivity syndrome, and 5 alpha-reductase deficiency who were assigned to be female developed a male gender identity and later transitioned to live as male. These individuals all had XY

chromosomes and were exposed to some level of fetal endogenous testosterone. This raises the question of whether gender identity could, in part, be a function of androgen effects on the brain. If that is indeed the case, it is important to ascertain when and how these effects occur. It seems likely that fetal hormones play a role but just how much and at what point in the process is a matter of speculation and further research.

Despite the questions raised to challenge the traditional medical management of intersexed infants, physicians are still seeking guidance on the best way to treat such individuals. In the medical literature, the general rule is to support the initial medical diagnoses and the subsequent surgeries (Byne, 2006; Mazur, 2005; Singh et al.; Zucker, 1999, 2002). One recent article reviewed currently available data on XY infants with atypical genitals.(Mazur, 2005) The conclusion was that the best predictor of adult gender identity was the initial gender assignment by the physician. This was despite the fact that the scant follow-up available indicated that nine of 99 persons with partial androgen insensitivity syndrome changed assigned gender as adults (Mazur, 2005).

This raises questions regarding many of the biases inherent in the medical approach to gender variance in newborns. The test of appropriateness for genitals tends to be phallocentric. This is partially due to the practical consideration of what surgery can adequately accomplish. Surgical “correction” of the genitals invariably means the creation of a vagina from something that was not an adequate penis. Penile construction in adults is extremely problematic and imperfect; it is not even a consideration in infants. Additionally, the adequacy of a penis was, in some cases, determined by the measured size. Those having a penis greater than a set length could keep it and be raised as a boy,

but those whose penis was shorter would have it removed, have a vagina created, and be raised as a girl (Mazur, 2005; Speroff et al., 1989).

However, one of the greatest problems in assessing the effects of gender assignment is the lack of good outcome data. Follow-up with many of the affected individuals is difficult and often does not occur. The bias in the existing data is for those who were available for, and agreeable to, follow-up. These were more likely to be those who had fewer problems with gender identity as adults. Given that gender identity difficulties are often associated with social stigma, psychological distress, and multiple other problems, it is not surprising that subjects were difficult to locate for follow-up (Burdge, 2007). Also, because of the associated stigma, many individuals may deny any issues regarding gender identity or may avoid the situation until a significant barrier to such a radical change is gone, such as the death of one's parents. Many of the studies didn't have a means of assessing gender identity as it only was assumed to align with a person's gender presentation. In actuality, stigma and other social pressures often prevent a person from revealing a gender identity that varies from their gender presentation. While all of the reports supported the continuation of genital reassignment surgery, many supported the idea of making the correct causal diagnosis and determining the appropriateness of surgery on a syndrome-by-syndrome basis. One paper actually mentioned the importance of input from those most affected, those who were born intersexed themselves (Byne, 2006).

It is clear that not all intersex conditions have similar etiologies or outcomes with regard to gender identification. For example, though there may be a wide variability in the appearance of the genitals, it is essential to differentiate a child with 5 alpha-reductase

deficiency from one with AIS since it could be anticipated that the child with 5 alpha-reductase deficiency will have a profound masculinization of the genitals at puberty. While it may seem evident that it would be unwise to try to create a female from this individual, the case of a child with partial AIS is far less clear-cut. Also, the visible maleness or femaleness of the genitals at the time of birth does not necessarily reflect the degree of the effects of androgens on the brain development.

Conclusion

This paper has provided information regarding a topic that is not part of the usual study for NPs and other nurses. Issues of gender ambiguity have been traditionally left for the physician to decide after informing the parents of possible options. However, all too often, the new parents are traumatized by the birth of a child with a condition that may be beyond their capacity to fully comprehend at the time. Often the physician's decision will be followed because the parents are bewildered and no other options are offered. Nurses can provide not only support but also important information and understanding regarding the condition. We can be advocates for the parents and also for the child whose best interest is often forgotten when they are not the perfect little boy or girl that was anticipated.

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Coming Out For A Third Time: Transmen, Sexual Orientation, and Identity

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Sexual orientation is often considered to be a stable, defining aspect of an individual's identity. However, a person's true orientation can be problematic, especially if it is socially stigmatized such as being lesbian or gay. Some choose to suppress their true orientation until they are ready to come out, a social process that is at the heart of self-acceptance and self-actualization for lesbian and gay people. Transgendered people, both male-to-female (MTF) and female-to-male (FTM) can undergo a similar, though not identical, process of coming out. The social stigma faced by transgendered individuals is even greater than that experienced by lesbian and gay people and the risk of loss of friends family and employment is more likely (Herbst et al, 2008). Many transgendered people, though not all, were gay or lesbian identified prior to coming out as transgender, thus necessitating coming out twice.

Since the first sex reassignment procedures were done in this country, many assumptions regarding the nature of transgender sexual identity have been promulgated by the medical establishment and accepted by the public at large. The original MTF narrative of a man born into a woman's body is one case in point. Early medical advocates for transgendered people such as Harry Benjamin picked up this narrative and linked transgender status to sexual orientation. One of the primary motives he suggested for sex reassignment for MTF was to create a normal heterosexual woman who could have sex with a normal heterosexual man (Califia, 1997). Transition for a transgender person was thus seen as a way of creating a heteronormative situation out of a homosexual one. An underlying assumption of the medical gatekeepers for transgender persons was that they desired a heterosexual life. Therefore, the notion that some transgender people could identify as gay or lesbian after transition is at complete odds

with this narrative. The fact that some of these individuals may have actually changed their orientation after transition is even more in conflict with this paradigm. For some FTM, or transmen, this has meant that they have come out three times in their lives; first as a lesbian, then as being transgendered, and finally as a gay man.

Of note, the San Francisco Department of Public Health recently added the acronym of TMSM to the larger group of men who have sex with men (MSM). TMSM refers to FTM, or transmen, who have sex with men, the recognition of a largely unidentified risk group within the MSM community. While it is timely that this group has received the attention it has, what is lacking is an understanding of the experiences that have led these individuals to identify as TMSM. This paper will provide an insight into the life experience of 17 transmen, the majority situated within the gay or queer community in San Francisco.

Review of the Literature

Transgendered people, in general, have been the focus of a number of studies that have explored the nature of gender and gender relations within society. In many ways they have been seen as pioneers at the nexus of sex, gender, gender identity, and sexual orientation and therefore have served to illuminate problems inherent in society's categorizations of gender (Dozier, 2005; Schilt, 2006). In this capacity they have often been portrayed as the transgressors of society's gender rules, or the gender outlaws. While this approach may result in important theoretical advances, it has done little to provide an appreciation or understanding of the transgender experience with regard to how persons who change their gender have managed to develop a sexual identity, resolve their gender dysphoria in the manner that worked best for them, and move forward with

their lives. The literature discussed here is therefore limited to research that is pertinent to the development of gender identification and sexual orientation for transgendered people, specifically with a focus on transmen.

The possibility of homosexually identified transgender persons was not recognized in medical research until relatively recently. An early study that documented the existence of gay and bisexual identity among FTM was published in 1993 (Coleman, Bockting, & Gooren, 1993). This report described the situation of nine FTM in the Netherlands who were sexually attracted to men. The conclusions were that this phenomenon may be more common than previously considered and that the discussion of sexual orientation among transgendered people, especially FTM, is complex and should consider more than just the presenting genitals, but also regard self-identification.

Since the time of the above study, the existence of gay FTM has been well documented. However this has been primarily in the area of HIV risk where it is understood that engaging in unprotected sex with gay men is potentially high risk for the acquisition of HIV. Also, FTM and MTF have often been grouped together when examining HIV risks (Herbst et al., 2008). In contrast, there have been several fairly recent studies that have examined the specific risks of FTM concerning sexual practices, perception of risk, and drug using behaviors (Kenagy & Hsieh, 2005; Namaste, 1999; Sevelius, 2009). The purpose of these studies was not to look specifically at the development of FTM sexuality but rather to examine how that sexuality placed them at risk.

A recent qualitative study examined the trajectories of FTM lives for the purpose of raising awareness among nurses (Morgan & Stevens, 2008). Semi-structured

interviews were conducted with four FTM and analyzed using narrative strategies that identified four primary themes: a) an early sense of body-mind dissonance, b) biding time until medical transition was possible, c) regret of the missed opportunities to transition that were not pursued, and d) the process of transition. Even though one participant self-identified as heterosexual and another as gay, there was no exploration of the sexual identity, orientation, behavior, or how these may have changed in the course of transition.

Several studies have examined the nature of sexual orientation among transgendered people (Bockting, Benner, & Coleman, 2009; Chivers & Bailey, 2000; Coleman et al., 1993; Daskalos, 1998; Smith, van Goozen, Kuiper, & Cohen-Kettenis, 2005). Chivers and Bailey (2000) questioned the notion that being a female-born transgendered person occurred almost exclusively among lesbian women. They recruited a convenience sample of 39 FTM who were in any stage of transition. The purpose was to compare what they referred to as homosexual and nonhomosexual FTM with regard to such variables as gender identity, partner preferences, sexual activities, and body modifications including phalloplasty. The authors classified the participant's sexual orientation based on their genetic sex, not their gender identity or the sex to which they transitioned. The data were all quantitative measures in the form of scales and questionnaires. The findings were important for the acknowledgment that FTM did not represent a homogenous group, as there were statistically significant differences in the scores of the variables between the homosexual and nonhomosexual groups. However, this is where the study proved to be problematic. Typifying FTM sexuality as dichotomous instead of uniform provided a small improvement in understanding the experience of sexuality within the context of being FTM. Using the differences of the

scores between these two groups suggested that group membership was an immutable aspect of the participants' make-up. In other words, sexual orientation was not considered to be something that could change or shift with the process of gender transition. Therefore, conclusions such as the homosexual types had preference for more feminine partners, experienced greater sexual jealousy, had more desire for phalloplasty, or were more sexually assertive than the nonhomosexual types seemed to echo heterosexual versus homosexual stereotypes. Also, the use of the term nonhomosexual FTM for a group of people who identified as gay, and homosexual FTM for those who identified as heterosexual was not only confusing but showed a disrespectful disregard for the actual experience and reality of the participants.

The same typology of homosexual and nonhomosexual was used in a study published in 2005 that investigated whether both FTM and MTF could be divided into the these subtypes, and if there were statistically significant differences among the groups (Smith et al., 2005). This study recruited 187 pretreatment transgender participants from the Netherlands. Treatment referred to some type of sex reassignment procedure and it was unclear how many participants, if any, were taking hormones. Differences between the FTM, MTF, homosexual, and nonhomosexual groups were compared. It was found that the homosexual transgender group applied for sexual reassignment at an earlier age, reported a greater childhood cross-gender identity, and tested better in psychological functioning than the nonhomosexual group. When the differences between homosexual and nonhomosexual for FTM compared to MTF were examined, it was found that the age difference in seeking sexual reassignment was not significant for FTM. The authors stated that the data suggested that using the homosexual and nonhomosexual subtypes for

transgenders had clinical and theoretical significance. All data presented were in the form of quantitative scales and questionnaires with the exception of sexual preference that was determined from semi-structured interviews. Interestingly, it was believed that there were only two transgender subtypes, homosexual and nonhomosexual, and all who claimed bisexuality or asexuality were placed in the nonhomosexual group. It is significant that this division was done prior to the sexual reassignment procedure and there was no consideration of the possibility of change in orientation as a result of transition.

Another study that used the same homosexual and nonhomosexual categories did find a change in sexual orientation among transgender participants after transition (Daskalos, 1998). The researcher used a nonrandom sample of 20 FTM and MTF, half of whom were postoperative. He divided the sample into homosexual and nonhomosexual groups based on their pre-transition biological sex. Four postoperative and two preoperative members of the heterosexual MTF group reported a shift in sexual orientation. This would mean a change from women as their object of sexual desire to men. The participants saw this as being a function of their emerging female gender identity and three of the six attributed the shift, in part, to the female hormones they were taking. This is interesting in that the shift in sexuality resulted in heterosexual females whereas the shift reported in FTM resulted in gay males.

One recent study found that sexuality among FTM required a paradigm other than the dichotomous homosexual and nonhomosexual (Bockting et al., 2009). This study was designed to improve the generalizability of Coleman and colleagues' 1993 study discussed above that examined sexual attraction to males among nine FTM in the Netherlands (Coleman et al., 1993). Twenty-five FTM from the United States who had

undergone sex reassignment and reported being attracted to men responded to interviews regarding sexual identity, behavior, and social support. Questionnaires concerning sexual identity, self-esteem, psychological adjustment, and sexual functioning were also employed. A comparison group of 76 nontransgender gay and bisexual men were also given the questionnaires. The FTM group demonstrated more bisexuality than the comparison group, but no other significant differences were found. The authors argued for an understanding of FTM sexual orientation that was tied to sexual preference rather than genital status and believed that it should be seen within the emerging paradigm of transgender sexuality. They also acknowledged the need for more qualitative studies to explore the development and nature of sexuality among transgenders.

In summary, we know from the literature that despite the stated goal of creating a heteronormative individual (Califia, 1997), medical sex reassignment will, at times, result in transgendered persons who possess a same-sex attraction toward the gender to which they have transitioned. What was considered anomalous twenty years ago is taken for granted by many researchers today. Further exploration is needed to understand the development of sexuality among FTM that goes beyond the typology of homosexual and nonhomosexual to incorporate the lived experience of the development of sexual identity in FTM as they transition.

Method

The design and conduct of the study were guided by interpretive phenomenology (Benner, 1994; Chan, Brykczynski, Malone, & Benner, 2010; Leonard, 1994), an inductive, interpretive method. This study employed the methods of interpretive phenomenology to analyze a series of interviews with the participants. There were two

distinct phases of the study which was conducted over an approximately 18 month time period. In the first phase, six participants were given a semi-structured interview of one to two hours. This was to gain an initial understanding of the population and the parameters of the experience being examined. Following the first phase, an additional 11 participants were recruited for the in-depth phase of the study, for a total of 17 participants. These additional participants had an initial in-depth interview of approximately one and a half to three hours in length. Each of these participants was told that a follow-up interview would be scheduled several weeks later. The follow-up interviews were focused on clarification of specific statements made by the participants and were 30 to 90 minutes in length. The data from both groups were analyzed together.

All of the participants were asked open-ended questions concerning their life story as a transgendered person. Each was asked to begin with their earliest recollection of their experience of being somehow different with regard to their gender identity. They were also asked specifically about how adolescence affected their sense of gender and developing sexuality. A history of sexuality, relationships, transition, and reactions to testosterone was elicited from all of the participants. The interviews for the in-depth group benefited from the prior experience in that more probes were employed and participants were asked to provide stories about specific incidents involving the negotiation of a sexual encounter, the effects of testosterone, or other aspects of transitioning.

The participants constituted a convenience sample and recruitment was similar for both groups. A local community based organization that provides counseling and social services for transgendered persons in San Francisco was contacted. The researcher spoke

with a counselor at the organization who was FTM and explained the nature of the study and provided contact information. The counselor then informed clients of the study and they were screened for eligibility by the researcher over the telephone. Flyers were also placed in the Lesbian, Gay, Bisexual, and Transgender Community Center in San Francisco and at a sex club in the city known to cater to both gay men and transmen. Participants were also encouraged to refer other transmen to the study. Inclusion criteria were that a person be at least 21 years of age, identify as a female-to-male transgender, have been taking testosterone for at least one year, and understand English. There were no specific exclusion criteria. The participants ranged in age from 23 to 64 with a median and average age of 36. Ten of the participants identified as White and the seven others identified as White/Hispanic, Hispanic/Native American, Hispanic, African American/Hispanic/White, White/Basque, Jewish, and Mixed Race. The number of years on testosterone ranged from one to 15 with a median of two years. This was a group of individuals who exhibited an enthusiasm for their work and for life in general. There were very articulate and eager to contribute to research that would increase public awareness of FTM. The study received approval from the University of California, San Francisco, Committee on Human Research, H642-32870-02A.

The analysis of the data was an ongoing process that began with the first interview and continued throughout the entire study. An interpretive memo was written within 24 hours of each interview. This addressed initial impressions relevant to the emerging lines of inquiry. All interviews were recorded and then transcribed. Transcriptions were read while listening to the recorded interview to correct any errors and to further appreciate the nuances of tone, expression, and pauses that cannot be easily

communicated with a written transcript. All transcripts were coded for emerging themes and categories using the ATLAS.ti computer program. In addition, an extensive case summary that focused on the lines of inquiry was written for each of the in-depth participants. These summaries examined the distinctions and commonalities among each one of these participants and the entire group of 17.

Three lines of inquiry emerged from the data; an exploration of how sexual orientation and behavior had changed for each of the participants as a result of transitioning and the implications of that change, the meaning of HIV and STD risk for the participants since transitioning, and the expected and unexpected effects of testosterone. This paper will examine the first line of inquiry, the possible shift in sexual orientation among the participants.

Many nurse researchers have adopted interpretive phenomenology, in part, because it examines the lived experience, or the lifeworld of participants concerning a specific phenomenon. Interpretive phenomenology goes beyond the description or explanation of a phenomenon to understand the meaning of the experience through the interpretive process (Mackey, 2005). It is that meaning of the experience that is placed in the foreground, or focus, of a study that is informed by phenomenology.

A phenomenological approach is particularly well suited to understanding the lived experience of FTM transgender persons, their sexuality, situatedness, the associated risks, and the actions taken either to engage in risky behavior or to reduce risk. The object of phenomenology is the experience and it is the body, one’s essential embodiment, and the actions of the embodied individual that are the focus of experience and is in the foreground of the analysis. Sexuality within the transgendered body can be seen as lived

experience whose meaning can be found in both the language of the research participant as well as their embodied habits and practices. The temporality associated with the transgender experience is also congruent with a phenomenological approach. The disunity of the past with the present with regard to self-identity has a major impact on the participants**.** Also, of primary importance, is an understanding of the meaning of the situatedness within the gay community for FTM. This situatedness has a direct impact on the concerns and subsequent actions of FTM with regard to sexuality.

It is this influence of interpretive phenomenology, the assumptions and the foregrounding of the lived experience, which informed the narrative analysis of this study. Narrative analysis itself can derive from many different research methodologies and can take a wide variety of approaches. The phenomenological approach to narrative analysis interpreted the stories that people constructed as revealing the things that matter and the meanings that they have for them in their lives (Benner, 1994). The habits and practices, or situated actions, of the subjects were interpreted with an understanding of their situatedness and temporality.

To interpret the experience of sexual orientation among FTM, it was first necessary to understand the larger story of the transition from female to male. Participant's narratives suggested that transitioning was a social process in much the same way as coming out as gay or the adjusting to a disease like diabetes. This process will be referred to as the "transgender trajectory". Each story was unique but there were identifiable common elements. The trajectory was comprised of a few key phases or categories that will be discussed in more detail. Although the phases are presented in a specific order, some individuals differed in their progression or occupied multiple phases

simultaneously. In a similar fashion, the duration of each phase was variable for each individual.

Transgender Trajectory

Gender dysphoria, a discomfort of varying intensity that resulted from the dissonance between gender identity and biological sex (Drescher; Ehrbar, Witty, Ehrbar, & Bockting, 2008; Singh et al.; Wallien & Cohen-Kettenis, 2008), marked the beginning of the transgender experience for all of the participants. For some, this was something they recalled from their earliest childhood memories, while others didn't experience the discomfort until adolescence began. Although considerable variability in the manifestations of gender dysphoria was evident, all participants reported some kind of gender discomfort. All names used are pseudonyms. As Skip recalled:

> I remember refusing to get dressed in the morning. And I must have been about three or four. I remember laying on the bed there, and my mother finally had to throw out these boys' clothes, it's the only way I would get dressed

The dysphoria ranged from feelings that female-identified clothing was simply wrong to outright resentment against their own bodies that sometimes resulted in self-harm. Cheyenne, who like many focused on his breasts as a source of dysphoria, provided a striking example and stated how his feelings were summed up in his "Freedom" tattoo:

> It kinda brought things to a head for me, because I never really thought of myself as a female. And when I got pregnant, I felt like my body really betrayed me. You know, female hormones, and it was really confusing, and I didn't want to go through pregnancy, so. And I had chest surgery about 6 months after I started transition—maybe sooner, I'm not sure. It was one thing I was completely sure of,

> you know, I wanted them gone. Even though they were very small, and I passed very well with them. I got a tattoo on my chest saying "Freedom." And it was inspired by that, the sense of freedom I felt, just to be able to take my shirt off and not, you know—to feel comfortable in my body.

The majority of the participants felt that their breasts were the primary source of their gender dysphoria which is consistent with other studies involving transmen (Dutton, Koenig, & Fennie, 2008).

As discussed earlier, a transgender narrative that was quite common in the past may persist in public notions of transgenders today is the idea that being transgender means that a person feels they were born with the body of the wrong sex. While this may be true for some individuals, it is certainly not a universal feeling among all transgendered people, nor is it a necessary aspect of gender dysphoria. As Lou stated, this narrative would be false in his own experience:

> And so when I came home to tell my family that I wanted to transition, I couldn't say I felt like I've been a boy my entire life, because I felt like that was a lie. Like there's no, to me there's no truth in that statement. I know that there's truth in that statement for other people, but it's not there for me. And so, I've always been gender-atypical from the time I was a little tiny kid. Just, you know, I always hung out with the boys and I was a tomboy. And, but I don't feel like I was ever supposed to be born a boy necessarily.

Being uncomfortable in a female body did not necessarily mean that the male sex represented the correct embodiment. For several of the participants, this dysphoria created a backdrop for other disorders including problems with eating, alcohol, heroin,

methamphetamines, or gambling, and psychological issues such as hyper-anxiety, self-abuse, and sexual addiction.

The early phase of the trajectory was characterized by a lack of vocabulary with which to put the cause of their essential discomfort into words. The absence of words or concepts to articulate what was happening to them resulted in a period of trying on different identities**.** This meant for many exploring behaviors and identities that seemed to make sense in the attempt to find a place that felt right. For example, the majority of the participants tried on a lesbian identity at some point in their lives. Another identity that many tried was one of being gender queer. Queer refers to a rejection of the gender binary and living one's life as neither male nor female but as a fluid free agent who moves without any commitment to one gender. Participants who identified as gender queer moved on from that identity when they found themselves identifying with the male side of the gender binary.

Very important and pivotal for all participants was the eventual realization of being transgendered. The description from all was of a moment of revelation that was triggered by some external stimulus. This could have been seeing Christine Jorgenson on television for the first time, going to a transgender film festival, meeting FTM people and realizing that they mirrored themselves, or speaking with a therapist who presented the previously unthought-of option of changing gender.

The next phase involved actions participants engaged in to ameliorate their discomfort. Some began testosterone right away and one participant began using it almost accidentally when a prescription was unexpectedly handed to him. For others it took years of waiting until they realized that the solution to their problem was feasible from a

practical and economic standpoint. Testosterone proved to be a key to transition and all required access to this key in order to realize transition.

Using testosterone resulted in changed bodies that allowed for passing, which meant being seen or “read” by others as being male. Many testosterone related changes were predictable and were anticipated by the participants. They included the voice changing to a lower register, the growth of hair on the face, chest and other typically male locations, redistribution of body fat to a male shape, and clitoral enlargement. All the participants commented on the hypersexuality brought on by the use of testosterone, a period almost universally described as a “second adolescence”. Although all felt the increased sexuality, its duration and the way it was acted upon differed for each participant. Testosterone also brought about unanticipated changes that many were not prepared for such as male pattern balding, aggression, menopause, and, for some, a change in sexual orientation. Although changing one’s body was the primary reason for taking testosterone, these changes could also be problematic. One case in point involved a participant who was newly diagnosed with HIV who was unsure how to properly protect his sex partners from possible infection when they performed oral sex on his transformed clitoris, given its close proximity to his vagina and vaginal fluids.

For some of the participants the testosterone was the last intervention in their transition. However, some form of gender reassignment surgery was extremely important for all. The majority had had mastectomies, or “top surgery”, and all felt that it was an essential component of their transition. Those who did not have the surgery cited economic reasons and were anticipating it when it could be afforded. More controversial was genital, or “bottom surgery”. It was well known and much discussed among FTM

that the current procedures for bottom surgery produced very mixed results and that many recipients were unhappy with their reconstructed genitals. Only one of the participants had had bottom surgery. That involved creation of a scrotum with testicular implants. One testicle reportedly fell off and the other was removed due to an infection. This participant was hoping that the techniques would improve so that he could try bottom surgery again. The other participants expressed a wide range of attitudes toward bottom surgery. Some were completely uninterested in changing their genitals whereas others expressed some interest if the results improved.

The final phase of the trajectory was the condition of being gay or queer. All of the participants identified themselves as either gay, queer, or both. As it will be explained, this had a different meaning for each of the participants. Several identified themselves as gay men prior to beginning the process of seeking medical care to enable transition. Some were lesbian identified and others were bisexual. However, it was the use of testosterone and other sexual reassignment procedures that allowed for the actual realization of living as a gay man.

Shift in Sexual Orientation

Of the 17 participants in the study, 10 identified as gay men at the time they were interviewed. The others identified as queer or fluid in their sexual orientation. All but two participants reported that they had gay men as sexual partners, either as primary or casual partners. The participants as a whole shifted toward having sex with men, specifically gay men, after starting testosterone, but this move should not be seen as a simple matter of lesbian orientation being supplanted by a new interest in men. Whereas the outcome at the time of the interviews indicated a change in sexual behavior from the sexual behavior

prior to transitioning, there were very distinct differences among the participants related to their orientation and activity prior to transition and at the time of the interviews. Four general patterns of behavior were observed: steadfast, aligned, shifted, and fluid. Each of these groups had its own specific concerns and considerations with regard the development of sexuality after transition.

All of the participants had feelings since childhood or adolescence that something about them was different, that they fit in some in-between world of gender that set them apart from others. Virtually all of the participants sought the lesbian community at some point in their lives because it provided a place where they could be comfortable with their difference. In this sense, the lesbian community was a source of acceptance and a certain validation that had been missing for many. For some, the experience in the lesbian community lasted a very short period until it no longer felt right or until transition made other options available. This was a period of trying on identity in the transgender trajectory that was replaced or augmented by other identities, such as being gender queer, until transition was made possible. Of the 17 participants, seven had had a lesbian identity that involved labeling themselves as lesbian, finding partners from the lesbian community, and obtaining political and social identity from within some aspect of lesbian community, be it lesbian politics, cabaret, or the punk/dyke/leather scene in San Francisco.

Steadfast

Several of the participants identified as lesbian prior to transition and they remained almost exclusively attracted to women after transition. These participants included Jasper, Skip, and Vic. At 44, 64, and 51 respectively, they were three of the

oldest participants. Although after transitioning to men, their attraction to women should have meant that they were technically heterosexual, these participants found this a difficult label to accept after a lifetime spent outside of a heteronormative existence. Having been part of the lesbian community was so important to their sense of self that they referred to their current orientation as queer, a term that encompasses any sexual orientation other than the strictly heterosexual. All three experienced gender dysphoria throughout their lives but that did not appear to impact their ability or desire to have sexual relationships with women who were members of the lesbian community. While all three had a history of sex with men prior to coming out as lesbian, both Jasper and Vic had no interest in pursuing biological males. For Vic, there was a lack of attraction and concern involving the risk in dating biological men:

> V: Yeah. Yeah, because I think a lot of bio men are fascinated now with having an extra hole to play with. And they sometimes take advantage of the situation and go bareback, you know. And that's something that I didn't want to have to sit there and negotiate for a half an hour before having sex, and having the whole thing just go flop.
>
> And I'm not-I've always been a top, so it's kind of difficult to give into a guy being my top. And usually that's what they're looking for.
>
> SR: Tell me, what do you-what are they looking for?
>
> V: For someone that they can be an aggressor over. Instead of being submissive.
>
> SR: Looking for a bottom.

V: Yeah. They want a bottom, they don't want another top. So for them, I think, there's very few men that you see out there that say "I want an FTM top." It's very rare.

Skip was not as absolute, though his primary sexual interest was women:

Well, I only played, I started playing around with guys, because I, men, erotically, turned me on. But I basically, erotically was turned on by women, and also want a relationship with women, so it's just more that way. And when I was in my '20s, I was fucking everything in sight. But I couldn't get that many women, I was having sex with a lot of guys, which I enjoyed, you know. And they were all very good, they were all good relationships. Then after I transitioned I'm much older and much more cautious, and so I played around with some guys. But some of the male places, they're barebacking, and-especially the other guy's bi, or gay, I mean, my god, you know.

And I do know a couple guys that's, they've got HIV from that. So it's just dangerous.

Skip was looking back on his sexual history and commented about the fact that he was probably bisexual as a teenager, to a great extend due to the lack of availability of other lesbians in his social circle. It was after his 20s that he then became almost exclusively lesbian and that is where he derived his sense of community. After he transitioned and the testosterone use resulted in a greatly heightened sexual desire, Skip wound up occasionally visiting peepshows and would involve himself in some of the masturbatory activities that occurred there. However, he did not get involved in the intercourse that he knew that other transmen engaged in, primarily because he became more cautious and

careful as he grew older and he did not want to become HIV positive which he saw happening to other transmen.

All three in the steadfast group had been using testosterone for over five years. They all reported the same initial sexual response to testosterone use. They felt as though they were going through a second adolescence and experienced a real hypersexuality. Unlike some of the others in the study, the effects of transitioning and their status of socially passing as men did not change their life-long attraction toward women.

One dilemma for these participants was the question of identification with the lesbian community after transition. Many commented about the transphobia within the lesbian community and the feeling among some that transmen had betrayed the community. Jasper had a great personal stake in the lesbian community and this was also the community from which he found, and continues to find, his sexual partners. However, after transition he found that his status as a man made him unwelcome in the social spaces he used to inhabit:

> I think some people felt that, you know, a sense of betrayal, in the lesbian community. And the funny thing is, is I'm a hundred percent honest, I felt that way a little bit too before I transitioned. And, like how can you leave our ranks, and that kind of thing And then I just-because, you know, I think it's really difficult to understand what it's like to be a lesbian in the '80s and '90s. Which was my experience, the '80s and '90s. I know it was more difficult before then. But my experience was that their politics can be really insular and really like, very protected, even if you're not like a separatist or whatever. There's so much oppression against women, and so much oppression against lesbians, you know,

> even more so. I mean, and it can come from such a disempowered place, that there's-I don't want to say just a victim mentality, but there's also just-I mean, there's rightly so, because of women are victims, of a lot of stuff that goes on in the world. And that you feel like you have to really tighten the boundaries of dyke-hood and you don't want to let your ranks be diminished.

Besides the question of how the lesbian community reacted to transmen was the question of how the transman related to his former life as a woman and lesbian. Jasper stated that he understood completely the feeling of resentment and betrayal that has now focused on him. How could one have it both ways, being a man and a lesbian woman at the same time? He also appreciated the fact that as a disempowered group, some lesbians felt the need to close the ranks in an almost insular manner to protect the "boundaries of dyke-hood". Interestingly, Jasper, referred to the lesbian community in the third person, indicating acceptance of his distance from it.

For others such as Vic, being shunned by the lesbian community was a real loss and there was some bitterness associated with it. He did, however, find a transgender group that had affiliated itself with less separatist elements of the lesbian community and this was providing him with a connection to the community that he felt a member of for so long. Skip, on the other hand, labeled himself as an outcast and hadn't yet found a community where he felt a sense of belonging.

Aligned

The largest group consisted of the six participants who experienced gender dysphoria to such an extent at the time of adolescence and later that a comfortable appreciation of sexual activity was impossible. They all had a life-long sexual attraction

for men but the sex itself was never right as long as they were female bodied and identified. The discomfort of the dysphoria gave them a feeling that something was wrong in the realm of gender and sexual expression. During their pre-transition life, most had relationships with men, these men treated them sexually as if they were women while internally they felt themselves men and needed to sexually relate to their partners as such. One participant, Sam, spoke about how he had resented being "feminized in bed" by men. Transition finally allowed for the correct alignment of gender and sexuality. LeRoy described just what that sense of alignment was like:

> Because I finally-like my gender and my sexuality were finally in the same place at the same time, and it was like, Ah! Finally, something is right. You know, like, for me my gender and my sexuality have always been very tied up in each other, and something somewhere was always amiss. So when they finally were there, together, I was like, Finally. I'm going to have the adolescence I never had, and be super excited about sex, because I never had it. So I wouldn't say that I was more interested in men, I was just acting on it more often because I was comfortable with who I was.

Ricardo spoke about how the alignment resulted in a change of his understanding of his own sexuality with his husband:

> I started realizing that sexually, I'm male. And it came in dreams, it came when I was with my husband, I just realized that I'm male sexually. Or I want to be the male in a sexual interaction. And that's when I really realized, "Wow."
>
> Well, this is interesting, 'cause you know for many-probably for most of our marriage I was the problem, sexually, in the marriage. Like I said, I was taking

> testosterone, libido, you know, I was kind of the identified problem. And that was really hard to take, to live with. And all of a sudden sex was better. Because see, not only, I didn't realize at the time that I was gay. But I'm, now I'm man and I'm a gay man, and so he just saw the sex was better. I know, I kinda knew why. But he didn't know, so, that went on for a while, and then I realized it was just too dishonest, I have to tell him. But it was, the interesting part is being sexual with him as a man, was much better than being sexual with him as a woman, even though the act was pretty much the same, 'cause obviously I don't have the parts. But it was different, 'cause there's a different connect, it's just a different connection.

Many used the same phrase of not being able to make love to a man until they were a man. All six dated men during their high school and college days and three of the six were married to men. However, prior to transition, these participants felt that something was wrong with the way they were sexually relating with their male partners. In the search for the right identity, all of them turned to the lesbian community for varying lengths of time. This was a social space that was accepting of female-bodied individuals who did not fit comfortably into a heteronormative lifestyle, though this trying on of identity never felt quite right, either. LeRoy spent several years identified as a lesbian, though it was primarily because he couldn't physically be a gay man:

> I was dating a man at the time, and I had met a bunch of women who were lesbians. And they were really nice and they liked me a lot. And I, I don't know, I mean I just felt confused. Like, literally what I was thinking in my head was, "Well I'm not-I guess I must be a gay woman." I was like, well, I don't feel

> comfortable being with men. I was female-identified. And I was-like, my thought was like, "Okay, well I guess that means I'm a gay woman." So it was like this default setting. Well, that means you're a gay woman.

For some, like Keith, even living within the lesbian community and having a lesbian identity did not stop a sexual desire for men:

> So I tried doing that (being lesbian), for two years. But I was always dragging home boys. And it just, you know, it just, I would crave-okay, I'll be crass, I would crave cock. And I wouldn't really have the same cravings for women.

In many ways these participants did not gain a lasting sense of identity or belonging from the lesbian community. Even within transmale circles, some felt that they were outside the norm due to their lack of a previous lesbian identity. Ben felt estranged from other transmen when he first transitioned because all the other transmen he knew had the experience of being lesbian that he didn't have:

> When I had that first partner I kind of dived into that (lesbian) community, and that just wasn't about me at all. That was just not me. … When I started becoming part of the transgender community…at first, the guys I met were all formerly lesbian-identified females.

So for these six participants, sexual desire did not change, but transition allowed it to finally be realized in the way that felt right, as gay men. It is interesting that four of the six stated that they identified as a gay men even prior to transitioning and passing as male. Even though it could be seen as problematic for some that their desire for men as men forced them into a gay social milieu, this is exactly what they felt and wanted all

along. Mick recalled the feelings he had when he started developing a sense of his own sexuality as a teenager:

> And I guess you could say I wanted to be a gay man more than I wanted to be a lesbian woman. But at that time I wasn't really even thinking in that kind of language.

However, for most of the aligned group, the world of gay men was completely new and the rules and modus operandi apropos of sex and cruising were quite foreign. This had real implications for vulnerability regarding the ability to negotiate safe sex or even knowing how to assess and discuss risk. For those who spent time within the lesbian or queer communities, this might not be so difficult, but for several members of this group there was a real confusion upon entering a gay man's world. The difficulty was not just a matter of negotiating safety but how to socially interact in a completely foreign milieu. This was especially true for Ricardo who was married and had no real contact with the gay or queer communities before his transition at age 44:

> R: Okay. Well, first of all, the gay culture has been very scary for me to think about, because I never knew of it. It was-
>
> SR: So how was it-tell me how you came to contact it?
>
> R: Well, it was, seeing my therapist, here in the city when I identified, realized I'm gay, I-there's places to go, obviously. Here, for gay men. But the difficulty, and the part I think was very scary for me, was how do I walk into a gay barjust even walking in a place where there's all men, interacting, how do I even enter that scene? You know, I'm used to walking in to places where it's men and women. And, how do you walk up-I just, it was just foreign to me. I felt like a

> teenager first learning to date, or-you know, what do you say, or how do you flirt, you know, all that. Didn't, still don't have much experience or clue in it.

Also LeRoy, who transitioned his early 20s, did not have much exposure to gay culture prior to becoming a gay man. Mick was an exception as he identified as a gay man early in his teenage years, had gay boyfriends, and was active in the queer and sex worker communities throughout his life. However, Mick was also the only participant who reported being HIV positive. He was infected shortly after he transitioned to being a gay man.

Unlike the steadfast group, transition for those in the aligned group did not mean the same loss of the lesbian community and its social and political identity. However, like all who are transgendered, they had families and friends who were impacted by the transition and some wound up losing relationships that have yet to be mended. The possibilities that were opened up by the alignment brought about by transition included relief of a lifetime of gender dysphoria and the subsequent sexuality as gay men. As was seen, this presented the possibility of sexual risk for which many were quite unprepared.

Shifted

There were four participants who had a rather dramatic shift in their object of sexual desire as they transitioned from a primarily lesbian orientation to that of being gay men. This was quite different from the previous participants, many of whom knew that they were gay men prior to transitioning. All of the men who shifted their sexual orientation stated that the change in the object of sexual desire from women to men happened completely unexpectedly. This group included Cheyenne, Chuck, Hank, and Thomas. Prior to transition, all were primarily lesbian with the exception of Hank who

was situated socially within the lesbian community but reported equal sexual attraction to both men and women that couldn't be fully realized while he identified as lesbian.

Chuck and Cheyenne both had very similar stories concerning the unexpected change they experienced. Chuck had a boyfriend for about six months at the time of the first interview. He had been lesbian identified since high school and moved to San Francisco in the 1980s to be a part of the growing punk/dyke/leather community. After realizing that he was transgender and subsequently beginning testosterone, he spent a summer working at a traveling rock festival with his lesbian identified girlfriend with whom he had initially thought he would remain. It was over that summer that Chuck noticed that not only was his body changing but his feelings were taking him to some very new places:

> C: But I did notice, I started really looking at boys on that summer, because there were so many hot sweaty shirtless guys running around. And I was sort of more looking-it started as looking at their body type.
>
> "What body type am I gonna have when this process is over and done with? …Then I was like, "Oh, he's kind of cute." And then it started going into, like, "Yeah, he'd probably be cuter if he was naked," and it really sort of progressed into this really kind of obsessing on guys, and kind of looking at them more sexually.
>
> SR: Had you ever done that before?
>
> C: No, not really.

Shortly after getting back to San Francisco after that summer, Chuck broke up with his girl friend and started living as a gay man. As his transition allowed for increasingly

better passing, he went from finding partners on heterosexual sites to using only gay-specific web sites.

Cheyenne had lived his life prior to transition as lesbian and he also had planned to continue with women as sex partners. He pointed out very clearly some of the aspects of being in a gay social situation that could be extremely rewarding for a transman:

> I-well, at first, I think the first six months, I was still kinda into women, but I was more, I was like "Whoa," noticing men, and definitely gay men were cruising me. And I felt validated by that, you know. 'Cause "they're men, and they're cruising me, so that must mean that I'm passing really well," you know. And then, it kinda shifted to-I don't know what happened, I stopped dating women and I just primarily identified as a gay man, and just started dating gay men.

Being cruised by gay men was validation that one was truly passing. The desire for passing, for many of the participants, became linked with a sexual desire for being with men. The factors here appeared to be the interplay of hormonal, psychological and social forces. Cheyenne also desired to be a recognized member of the gay community, so much so that he also saw being HIV positive as a further validation of his gay male status:

> I was-okay, well, my partner right now is positive. We're non-sexual. We used to be sexual. And I think maybe that's another reason that we're not sexual, I think for him there's a little bit of a hang-up, maybe, about him being positive, like not wanting to infect me. But also me not having a penis, and also, you know, we're not sexual. But we used to be.
>
> And there was something that happened one time, I felt like everybody around me was positive I felt I was already different and already left out, and I just, you

> know, it sounds-whatever, I know I'm not the only one that felt that way. Just, you know, and it felt like I already had a disease with my blood that could put people at risk, you know, with having hepatitis. But it wasn't really giving me a sense of belonging, or giving me free acupuncture, free massage, free reiki, free housing, free this and that.
>
> You see other people, like, getting hooked up with benefits, and you're like having unprotected sex and you're not getting positive.
>
> I was getting off on putting myself at risk, you know. And I was even telling people I was positive so they wouldn't have, you know, issues about being with me sexually.

Cheyenne started telling HIV positive sex partners that he was already HIV positive so that they wouldn't feel compelled to use condoms and so that he might finally become part of the positive community. This didn't happen as Cheyenne eventually broke up with his boyfriend due to the unfortunate transman incompatibility for many gay men- the lack of a penis.

Thomas, who was in his mid 40s, still lived with his female lover from his lesbian life prior to transition, though they were no longer having sex. Even though he had limited experience acting upon it, he also had an unexpected shift in the object of his sexual desire:

> I am one of those guys that experienced a radical shift in orientation during transition. Yeah, well, that's when it came, really came to fruition. I mean I definitely started role-playing when I was involved in the leather scene, prior to transition. But I definitely went from being as interested or more interested in

> women, to being much more interested in men. And I mean, I can surmise that being a little more comfortable with my own body, freed up other things going on with how I looked at other people, or what interested me. But I honestly don't know, it's still like one of those great mysteries for me of what happened.

When he began using testosterone 15 years ago, Thomas had every intention of remaining with his partner until he found that his sexual orientation shifted. Unlike Chuck, who decided to pursue gay men when his relationship with his female partner ended, Thomas' situation became more complicated. His partner developed a serious illness shortly after Thomas transitioned. This resulted in severe mobility problems and Thomas chose not to abandon his former lover but out of loyalty remain in the relationship. In theory the relationship was sexually open. However, Thomas felt quite ambivalent about seeing men on the side. A sexual encounter could lead to a romantic involvement and a possible break-up with his partner. To avoid such a conflict, Thomas rarely acted upon his sexual desire.

Hank stated that he had been a lesbian politically and socially. However, he was attracted to men and women equally though it was really his new situation of being within a gay social environment that enabled him to change:

> H: I definitely have hooked up with a lot more men since physically transitioning and socially transitioning. And to a large degree, that has to do with the social situation, as far as the way I'm being read. But on the other side, where before transitioning and even the first year, year and a half of transition, I saw potential partners pretty equally as far as gender goes. Was attracted to men, attracted to women, or in between.

> Now, more recently, probably in the past six months or so, it's shifted much further away from women and much more towards men. You know, if somebody like threw themselves on me I probably wouldn't say no as far as women go, but like, I'm actually much more… much gayer, now. (laughs)
>
> SR: Which is interesting, since you did identify with the lesbian community.
>
> H: Yeah, and that's been-I think that's been part of it too, is I don't necessarily feel as much of a part of the lesbian community since physically transitioning. Or at least passing much more. I mean, a lot of people in the community know me, so it's not you know, incredibly awkward, but I feel strange hanging out in a dyke bar.

After transition his interest shifted dramatically to the men's side of the equation and he was comfortably situated within the gay community when interviewed. At that time he stated that he had recently broken up with a girlfriend and was in the process of looking for a "cute guy".

Fluid

The final four participants seemed to be genuinely bisexual, or fluid in their sexual orientation, and transition made sex with gay men more of a possibility without really changing the nature of their desire. This group included Lou, Lucas, and Ski, who all had primary relationships with women but also had sex with men on the side. However, even though they had female partners, they identified themselves as bisexual or queer men. At the time of the interview, Karl was without a partner and was ambivalent regarding whether he wanted a female partner or if he would continue his transitioning to eventually become a gay man.

The attitude with which each participant approached his sexuality was somewhat unique. Lucas stated that he really did not like being emotionally close to men. He needed women for his emotional needs, so he had a girlfriend and had anonymous hookups with men every few months just to get the physical need out of his system, He had arrived at this solution after several different periods in his life where he had dated men and women exclusively.

> I didn't identify as a lesbian, I just didn't want to date men at that time. Because I had become obsessed with women. I just had become obsessed with like, the relationship with women. I realized that I didn't really have much of an emotional connection with men, when it came to dating. So I didn't want to further that anymore, I didn't want to waste my time dating men. It was more of just a sexual thing. But with women, I had-I felt like an emotional connection and I liked the relationship dynamics with women. And that's still how it is, with me, to this day, is like, wanting to date women for emotional reasons, and sexual. But men, I'm still interested in them sexually.

At the second interview, Lucas stated that he had begun to rethink his view of men as being only for sexual purposes and not for a complete emotional relationship. He had started to date a man that he hoped would be able to fulfill both needs.

Karl tried on a lesbian identity for a brief period of time but he found the fluid nature of his experience was problematic:

> Well, I think that, one thing that's also been a thread through my life, is that I feel like I have a lot of fluidity in me, that doesn't anchor me solidly into any camp

that I can hold on to. And so, things like sexuality and gender all seem… they all fluctuate so much that it's a little difficult to locate myself in any one place.

Perhaps because of this difficulty in locating himself, Karl sought out men after he started transitioning in order to help him understand the masculinity that he was taking on for himself:

K: I would say that I probably had an equal attraction. I think that it was an issue of accessibility and an issue of, like, who I wanted to be in relation to my sexual partners.

SR: For example? What do you mean by that?

K: Sure, well, I don't think that I ever wanted to be the woman counterpoint to a man. So I didn't want to have sex with men as a woman. And then I think that-you know, increasingly it's become difficult to be a man to someone's woman, if that makes sense.

SR: To a female-identified person.

K: Right, yeah.

SR: It's difficult to be a man to a female-identified person?

K: Mm-hm. Like that doesn't feel right to me either.

SR: What feels right?

K: I'll let you know when I figure it out.

Karl had a brief affair with a man 40 years older than himself so he "could be desirable" and fulfill a role he understood "somebody's younger boy". After seeing women again briefly he desired for more contact with and recently hooked up with men who were closer to his own age. He was ambivalent regarding the masculinity that he was starting

to manifest and was taking his transition at a slower pace than the other participants. He provided a possible explanation for seeking men as sexual partners:

> I started to be more interested in trying to describe and define to myself what masculinity might mean. And I think that's what led me to have these encounters with men. So I think that the testosterone was sort of the-I would imagine it was the impetus for the sleeping with men, but I don't know if it was because I was more sexualized, or it was more related to my identity exploration

Both Lou and Ski described their identity as queer or bisexual and they spent a short amount of time in the lesbian community though they felt that the label was not appropriate for them. They felt comfortable having a steady relationship with a woman and having an occasional fling with a gay man. This was very different from the gay identity that Clay and Eliot, of the shifted group, unexpectedly transitioned into.

For this group of sexually fluid transmen, something occurred that opened the door of sexual possibilities that had been previously limited. Lucas was able to describe what happened for him:

> I don't really know. I think that I just started thinking about sex more after I started taking hormones.
>
> And also, me being more comfortable with my own body, as I transitioned and everything and realizing -- and I've always identified as a fag even when I dated women. That's always how I just felt inside. So, you know, the more I'm comfortable in my own body …I'm just more comfortable with being in a gray area of sexuality, I think. Oh, like dating everybody or date -- you know being

really attracted to men as well or some men and wanting to, you know, date them as well as women.

As stated earlier, all of the transmen experienced some kind of gender dysphoria early in life. For many the discomfort they felt within their own bodies created a barrier that prevented them from being able to express their sexuality. Many had desire for men sexually but couldn't make love to a man while they were female bodied and identified. Karl described how his dysphoria led him to feel such a disconnection with his body that he stopped taking care of himself:

K: I don't have early memories of feeling like I was a boy, or I-you know, I think that I grew up and felt like a pretty little girl, and that felt fine for me. And then I think maybe around puberty, I started to feel like, disconnected from my body, but not with the orientation of feeling like I was a boy, but just feeling like I didn't like the physical changes in my body, I didn't like the development of my, like, secondary female characteristics. And-

SR: Do you know how you reacted to that at the time?

K: I just wore really baggy clothing, and I stopped doing a lot of self-care. I stopped, you know like, brushing my hair, and I just stopped grooming basically. I think I just stopped caring for myself because I didn't want-I didn't know how to-there was no avenue where I felt I would feel successful as a woman or as a girl, so I just kind of stopped trying.

He eventually started cutting and burning himself. Despite the intervention of a school therapist, this activity did not stop until his early 20s. It is interesting that issues of gender dysphoria were never brought up during his therapy sessions. The majority of the

participants reported some kind of problem while still in school that resulted in counseling sessions. However, only Mick's counseling sessions involved any discussion of gender issues and that ended when Mick revealed his sexual orientation to the counselor who balked at the notion that Mick wanted to transition in order to "become a fag".

Discussion

Of the 17 transmen who participated in this study, all but two stated that they had gay men as sexual partners after transitioning. All described themselves as either gay or queer. The participants, in general, shifted to a sexual preference for men; however, it was primarily in the aligned and shifted groups that the most dramatic change in sexual activity occurred. Whereas the absolute cause of the new gay identity among the transmen in this study is impossible to determine, three important factors for all were testosterone, the process of transition, and the social context.

Testosterone

Even for those who had a sexual attraction to men prior to transition, it was the testosterone that enabled them to pass as a man, validated their male gender identification, and diminished gender dysphoria. For them, testosterone was the key that opened the door of sexual possibilities. Whether the effects of the hormone itself caused a shift in sexual orientation is a matter of speculation and further inquiry. Of interest is the study by Daskalos (1998) where three of the six MTF who reported a change in sexual orientation toward men attributed it to the effect of the female hormones they were taking. In contrast, while the transmen in this study noted the increased sexual desire

brought on by the use of testosterone, none of the shifted group believed that it was responsible for the actual change in desire.

The Process of Transition

The period when the participants first starting using testosterone for transition was described almost universally as a second adolescence, better than the first. Like the first time around, this adolescence was characterized by sexual experimentation. It could be argued that the shift to men as sexual partners was simply a factor of that experimentation. In early transition, many did report that they sought out men as sex partners in order to understand the male sexuality that they were transitioning into. Because this occurred during the early phase of transition, many of the participants were not passing as convincingly as they would after more time on testosterone. Many would present themselves as butch lesbians on online sites that catered to heterosexual and bisexual men. The physical changes brought on by the process of transitioning and testosterone eventually allowed a graduation from those sites to Internet sites specifically for gay male sexual cruising. Over time the experimentation with men became, for some, an ingrained preference. It is also of note that the shifted group had been taking testosterone for an average of 8 ½ years and had therefore, greater experience passing and living as men than any of the fluid group, who averaged just over two years on testosterone. It is conceivable that given more time passing as male, the sexuality of the fluid group might move more toward gay men, such as the case of Lucas who expressed a definite increased interest in men in the two months between interviews. However, the steadfast group, with an average of eight years taking testosterone, demonstrated that time and male hormones did not necessarily result in a shift of sexual orientation.

Social Context

The final factor is the social context of transition. Many of the participants transitioned from within the gay and queer communities in San Francisco. All of them wound up living within them. Both socially and geographically, these are extremely visible communities within the larger city. Changes over the past several decades in politics and demographics have resulted in a burgeoning queer community that has a broader inclusiveness than the narrower focus of the gay male centered community. A queer consciousness embraces a wider range of experience with regard to sexual expression, economic status, and political beliefs. Bockting et al (2009) mentioned the emergence of a transgender sexuality as an identity distinct from the gay sexuality that their participants were claiming. This was seen as an experience of sexuality that differed from a nontransgender male or female sexuality and, in many ways, represented a form of sexuality outside of the gender binary.

In contrast, this study found that within the context of a city such as San Francisco, with its wide sexual diversity and greater tolerance relative to the rest of the country, a discrete uniform transgender sexuality did not emerge as shared experience for the participants. Their sexuality was a part of the fabric of the overall queer sexuality and not necessarily a separate entity. The participants stated that they identified their sexuality as gay, queer, or bisexual. That identity was not based just on themselves but also their partners and how they identified. Instead of possessing a distinct transgender sexuality, the presence of transmen within the gay community can be seen as expanding gay sexuality into a more queer realm. None of the participants could conceive of identifying as heterosexual as it represented a community and way of being that were

both foreign and unappealing for all. While most of the participants used the terms queer and gay interchangeably, there were several who identified themselves as unequivocally gay. These were transmen who did not identify with the transgender community or with any notion of transgender sexuality. They did not reject the gender binary. Instead they saw themselves as aligning with the male side of the dichotomy. What was important for these transmen was their complete integration as gay men and as part of the gay community.

Sexual Orientation

This study challenges several assumptions regarding the nature of transgender identity and its relationship to sexual orientation. It is intended to be a contribution to a growing body of work that examines the sexual identities of individuals who have transitioned. One of the primary assumptions questioned is the notion that having gender dysphoria that results in a transgender identification is inextricably linked to a person's sexual orientation. From that idea developed the belief that there were two distinct subtypes of transgender who could be viewed through the lens of their immutable pre-transition sexuality, homosexual and nonhomosexual (Chivers & Bailey, 2000; Smith et al., 2005).

The participants in this study characterized their sexuality prior to transition in a variety of ways. This ranged from a definite identification as lesbian to a heterosexual orientation that did not involve any lesbian identity. The majority of the participants were somewhere in between and did not feel comfortable with their sexuality until they transitioned into the gender presentation that matched their gender identity. The subtype system referenced above classifies individuals solely on a criterion of sexuality relative to

genetic sex, meaning that former lesbian and bisexual participants are considered homosexual subtypes and heterosexual participants as nonhomosexual. These subtypes, and thus sexual orientation, have then been used as a means of explaining differences in why and when transgendered people sought sex reassignment. In other words, that there were distinct transgender developmental processes for homosexuals as compared to nonhomosexuals (Smith et al., 2005). Sexuality was therefore seen as a determinant of transgender development. However, in this study, sexuality was found to be an unpredictable outcome of transition, not a motivating factor for transition.

The reality for the participants in this study was more complex and was characterized by a great variability in sexual identity and expression. In part, this variation was due to the fact that, for the participant who had experienced gender dysphoria, the transition to being male opened up sexual possibilities that had been previously unavailable. This was especially evident in the aligned and shifted individuals. Many of participants made similar statements regarding being attracted to men from an early age but something was always amiss because the nature of the sexual relationship was a heterosexual configuration requiring that they assume the female role. This was consistent with the findings of other studies that explored gay identity among transmen (Bockting et al., 2009; Coleman et al., 1993). For both the aligned and fluid participants, the possibility of being gay or queer was made real. Many participants in these groups had felt an identity as gay men prior to transition but this did not make sense until testosterone enabled them to live as men. Thus, transition allowed for the actualization of situated possibilities of sexuality.

However, unlike the study by Coleman et al. (1993), where it was found that all of the participants had a sexual attraction for men prior to transition (p. 41), the four shifted participants were essentially taken by surprise by their predominant sexual attraction to men over women. For all four, this occurred after they began passing as men. These individuals rendered the subtyping of transmen into homosexual and nonhomosexual categories as being of questionable value.

Limitations

Limitations of this study are a result of the number and type of participants. A small sample of 17 individuals cannot be used to generalize to the unknown number of transmen in the United States. Also the criteria for this study included the stipulation of a transition using testosterone for at least one year. Not all individuals who identify as transgendered choose to use hormones for transition or even to transition at all. It is likely that those people who do not use hormones would have a very different experience. Also, all of these participants lived in an urban environment. The experience of those who live in a rural or suburban area could also be very different. A greater variety in racial and economic background of the participants would provide a broader understanding of the phenomenon. The sexuality of the participants was assessed through questions that asked for self-identification. Sexuality was not separated into discrete aspects of fantasies, desires, and behaviors. Since the concept of sexual orientation is problematic because behaviors and feelings are often incongruent, it is hoped that this qualitative assessment enriches and corrects previously specified categories.

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Too Much Of A Dude For A Straight Guy: Transmen, Situatedness, and HIV Risk

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Since the beginning of the HIV epidemic, men who have sex with men (MSM) have been identified as one of the highest risk groups for the acquisition of HIV and STDs (Buchbinder, 2007; Wong, Chaw, Kent, & Klausner, 2005). Researchers and public health departments in the United States have also recognized that male-to-female (MTF) transgenders, or transwomen, are at a particularly high risk for STDs and HIV (Herbst et al., 2008). However, the lives and experiences of female-to-male (FTM) transgenders, or transmen, have in comparison been much less visible. Of note, the San Francisco Department of Public Health recently added the acronym of TMSM to the larger category of the risk group MSM. TMSM refers to transmen who have sex with men, the recognition of a formerly unidentified risk group within the larger MSM community. While it is timely that this group has received the attention it has, an understanding of the experiences that have contributed to these individuals being at risk is not readily available. This paper will examine HIV and STD risks of 17 transmen, the majority situated within the gay community in San Francisco.

Review of the Literature

A number of studies have examined the HIV and STD risks among MTF transgenders and several recent studies have examined the HIV risks of transgender persons in general. However, there are few studies concerning the risks specifically for FTM transgenders. A quantitative study done in San Francisco examined HIV risk and prevalence for both MTF and FTM transgender people (Clements-Nolle, Marx, Guzman, & Katz, 2001). Interviews and HIV testing were conducted with 392 MTF and 123 FTM. They found HIV rates were much higher for MTF (35%) than for FTM (2%). An analysis of factors that were independently associated with HIV prevalence was conducted for

MTF but not for FTM because of the low prevalence. However, it was noted that 50% of the FTM identified as gay or bisexual men and over 60% of all the FTMs reported unprotected vaginal sex with a male and 27% reported unprotected anal sex with a male partner, though the majority of the risk occurred more than six months prior to study participation. It was found that the prevalence of suicide attempts among FTM, 32%, was much higher than both United States household probability samples and recent findings for MSM. The majority of the FTM were using testosterone, although it was not correlated with risk, sexual behavior, or suicidal ideation.

In contrast, another study found that FTM were more likely than MTF to engage in high risk sexual activity and had less AIDS knowledge (Kenagy & Hsieh, 2005). This study used a needs assessment survey of 122 MTF and 62 FTM recruited from Philadelphia and Chicago. Unlike the San Francisco study, the researchers found that the majority of the FTM, 58.1%, identified as gay men and 81% reported high-risk sex during the three months prior to study participation compared with 55% of the MTF. Unfortunately the researchers included the lower risk activities of unprotected oral sex, both mouth to penis and mouth to vagina, in the high-risk category. They also did not distinguish between those participants who may be in monogamous relationships, where condom use may not be necessary, from those who were at risk due to multiple, unprotected partners. These factors very likely inflated the reported risk. Despite these limitations, the study demonstrated that FTM could not be assumed to be low-risk based on low HIV prevalence rates. This study supported the findings of smaller earlier study where an HIV risk assessment was conducted among FTM transgenders and transvestites in Quebec (Namaste, 1999). The data for the study were provided by interviews with five

FTM and one discussion group of unknown size. Five areas of HIV concern were identified for FTM: a) lack of information concerning FTM bodies and sexuality, b) denial of risk among many FTM, c) poor access to clean needles for testosterone injections, d) low self esteem which was believed to result in a reluctance for FTM to adopt safe sex practices, and e) the exclusion of FTM from many social service agencies. The report lacked any information specific to actual sexual behavior and/or risk.

Several studies have examined the use of testosterone among FTM from very different perspectives. Researchers in San Francisco examined how testosterone use among FTM could be related to well-being (Newfield, Hart, Dibble, & Kohler, 2006). The Internet was used to recruit 446 FTM for a survey that examined quality of life. The FTM respondents exhibited significantly lower quality of life scores than non-transgendered respondents, especially with regard to mental health. Those FTM who reported use of testosterone had significantly higher quality of life scores than those who did not. The study also explored “top surgery”, or mastectomy, as another correlate of quality of life and found it predicted quality of life in the general health domain but not in social functioning or mental health. One study examined the long-term physical effects of hormones on both FTM and MTF who attended a gender clinic in Amsterdam from 1975 to 2006 (Gooren, Giltay, & Bunck, 2008). Included in the study were 876 FTM who received parenteral testosterone. The short and medium-term testosterone use did not appear to cause any significant cardiovascular, cancer-related, or liver problems; however, the long-term effects were unknown. The subjects were followed for a maximum of 31 years but no temporal definitions of short, medium or long-term were

provided. This study examined only quantifiable physical effects and did not consider psychological, emotional, or sexual effects.

Herbst and colleagues (2008) conducted a meta-analysis of studies involving HIV prevalence and risk among transgender persons in the United States conducted from 1990 through 2003. Of the 29 studies cited, the majority of the data concerned MTF and only five studies had separate data concerning FTM. HIV prevalence rates for FTM were reported to range from 0% to 3%. No HIV incidence rates were found in the literature. Even among these five studies, results were at times quite disparate. In examining nonsexual risk behaviors, two studies found no IV drug use among FTM, while one study found 21% of its sample reported IV drug use. Sample sizes ranged from 32 to 123 and the ethnic makeup of the samples ranged from predominantly White to one study that was 75% African-American. The authors concluded that while there was a definite HIV risk reported for FTM, there was very little data as to the detailed nature of that risk and that more in-depth studies were necessary. Specific areas that were suggested for investigation included the effects of hormone use on sexual risk and the exploration of the social networks of sex partners (Herbst et al., 2008).

Sevelius published a study that examined the specific HIV risks of transmen who had sex with nontransmen and how they perceived the impact of gender identity and gender expression on sexual decision making (Sevelius, 2009). She found that there was considerable sexual risk among transmen who had sex with nontransmen and factors that contributed to risk included unequal power dynamics, low self-esteem, and a need for gender identity affirmation. Despite the high-risk activity documented, transmen still had reported low rates of HIV. This, in part, was determined to be due to such protective

strategies as online meeting that could allow for both disclosure and safe sex negotiation prior to an actual face-to-face encounter. The paper reported that there was anecdotal information concerning transmen changing sexual orientation in the course of transitioning.

In summary, we know from the literature that there is a population of FTM who are definitely at risk for HIV and other STDs based on a limited number of surveys of risk activity in a few major cities in the US. It is documented that a number of the FTM involved in the studies reported men as sex partners; some identified as being gay. While rates of depression have not been well studied, rates of suicide attempts are high among FTM and depression can affect risk-taking behavior (Herbst et al., 2008). Many of the FTM reported using testosterone, which one study found improved their quality of life, and it is believed that the short-term side effects of testosterone are benign while the long-term effects are unknown. Nothing found in the literature examined the experience of being FTM with regard to how changing sexual identity, which potentially places them within a high-risk sector of the gay community, actually affects risk and behavior. There is also a lack of information regarding how transitioning from a variety of other communities into the gay community impacts risk. These gaps reinforce the need to explore how the process of transitioning to living within the gay community might have unique implications for risk among FTM.

Method

The design and conduct of this study were guided by interpretive phenomenology (Benner, 1994; Chan, Brykczynski, Malone, & Benner, 2010; Leonard, 1994), an inductive, interpretive method. The study employed the methods of interpretive

phenomenology to analyze a series of interviews with the participants. There were two distinct phases of the study, which was conducted over an approximately 18 month time period. In the first phase, six participants were given a semi-structured interview of one to two hours. This was to gain an initial understanding of the population and the parameters of the experience being examined. Following the first phase, an additional 11 participants were recruited for the in-depth phase of the study, for a total of 17 participants. These additional participants had an initial in-depth interview of approximately one and a half to three hours in length. Each of these participants was told that a follow-up interview would be scheduled several weeks later. The follow-up interviews were focused on clarification of specific statements made by the participants and were 30 to 90 minutes in length. The data from both groups were analyzed together.

All of the participants were asked open-ended questions concerning their life story as a transgendered person. Each was asked to begin with their earliest recollection of their experience of being somehow different with regard to their gender identity. They were also asked specifically about how adolescence affected their sense of gender and developing sexuality. A history of sexuality, relationships, transition, and reactions to testosterone was elicited from all of the participants. The interviews for the in-depth group benefited from the prior experience in that more probes were employed and participants were asked to provide stories about specific incidents involving the negotiation of a sexual encounter, the effects of testosterone, or other aspects of transitioning.

The participants constituted a convenience sample and recruitment was similar for both groups. A local community based organization that provides counseling and social

services for transgendered persons in San Francisco was contacted. The researcher spoke with a counselor at the organization who was FTM and explained the nature of the study and provided contact information. The counselor then informed clients of the study and they were screened for eligibility by the researcher over the telephone. Flyers were also placed in the Lesbian, Gay, Bisexual, and Transgender Community Center in San Francisco and at a sex club in the city known to cater to both gay men and transmen. Participants were also encouraged to refer other transmen to the study. Inclusion criteria were that a person be at least 21 years of age, identify as a female-to-male transgender, have been taking testosterone for at least one year, and understand English. There were no specific exclusion criteria. The participants ranged in age from 23 to 64 with a median and average age of 36. Ten of the participants identified as White and the seven others identified as White/Hispanic, Hispanic/Native American, Hispanic, African American/Hispanic/White, White/Basque, Jewish, and Mixed Race. The number of years on testosterone ranged from one to 15 with a median of two years. This was a group of individuals who exhibited an enthusiasm for their work and for life in general. There were very articulate and eager to contribute to research that would increase public awareness of FTM. The study received approval from the University of California, San Francisco, Committee on Human Research, H642-32870-02A.

The analysis of the data was an ongoing process that began with the first interview and continued throughout the entire study. An interpretive memo was written within 24 hours of each interview. This addressed initial impressions relevant to the emerging lines of inquiry. All interviews were recorded and then transcribed. Transcriptions were read while listening to the recorded interview to correct any errors

and to further appreciate the nuances of tone, expression, and pauses that cannot be easily communicated with a written transcript. All transcripts were coded for emerging themes and categories using the ATLAS.ti computer program. In addition, an extensive case summary that focused on the lines of inquiry was written for each of the in-depth participants. These summaries examined the distinctions and commonalities among each one of these participants and the entire group of 17.

Three lines of inquiry emerged from the data: an exploration of how sexual orientation and behavior had changed for each of the participants as a result of transitioning and the implications of that change, the meaning of HIV and STD risk for the participants since transitioning, and the expected and unexpected effects of testosterone. This paper will examine the second line of inquiry, the implications for risk that resulted from transitioning.

Many nurse researchers have adopted interpretive phenomenology, in part, because it examines the lived experience, or the lifeworld of participants concerning a specific phenomenon. Interpretive phenomenology goes beyond the description or explanation of a phenomenon to understand the meaning of the experience through the interpretive process (Mackey, 2005). It is that meaning of the experience that is placed in the foreground, or focus, of a study that is informed by phenomenology.

A phenomenological approach is particularly well suited to understanding the lived experience of FTM transgender persons, their sexuality, situatedness, the associated risks, and the actions taken either to engage in risky behavior or to reduce risk. The object of phenomenology is the experience and it is the body, one's essential embodiment, and the actions of the embodied individual that are the focus of experience and is in the

foreground of the analysis. Sexuality within the transgendered body can be seen as lived experience whose meaning can be found in both the language of research participants as well as their embodied habits and practices. The temporality associated with the transgender experience is also congruent with a phenomenological approach. The disunity of the past with the present with regard to self-identity has a major impact on the participants**.** Also, of primary importance, is an understanding of the meaning of the situatedness within the gay community for FTM. This situatedness has a direct impact on the concerns and subsequent actions of FTM with regard to sexuality.

It is this influence of interpretive phenomenology, the assumptions and the foregrounding of the lived experience, which informed the narrative analysis of this study. Narrative analysis itself can derive from many different research methodologies and can take a wide variety of approaches. The phenomenological approach to narrative analysis interpreted the stories that people constructed as revealing the things that matter and the meanings that they have for them in their lives (Benner, 1994). The habits and practices, or situated actions, of the subjects were interpreted with an understanding of their situatedness and temporality.

Results

An examination of how sexual orientation shifted for the participants of this study as a result of transition was reported in a previous paper. The majority of the participants found that their sexual attraction was focused on biological men after transition and 14 of the 17 stated that they had gay men as sexual partners. Four identified as bisexual and had both gay men and women as partners. Ten identified as gay men and were the most invested in being in the gay community. For many, the ability to make love to a man in a

way that felt right for them had finally become possible. Only the three participants who still retained a primary sexual attraction for women remained outside of gay male circles when looking for partners. None of the participants had phalloplasty, but 13 of the 17 had a mastectomy, or top surgery.

Information regarding HIV status of the participants was obtained by self-report. All tested for HIV on a regular basis. One participant reported that he received a positive HIV result approximately six months prior to his interview. He stated that all the anal and vaginal intercourse he had engaged in was protected so he was uncertain how infection occurred. However, he also engaged in S & M activities that involved some blood play so that was one possible route of infection. Two of the 14 had hepatitis C that was most likely contracted through past histories of needle sharing.

All of the 14 participants who had nontrans male partners, whether they identified as gay, bisexual, or queer, stated that they had multiple partners. Several were in relationships but these were not strictly monogamous and allowed for other sexual partners. One participant had been in a relationship with a female partner that began before he transitioned. Although they remained together, the relationship was no longer sexual. One participant had been with his boyfriend for almost one year and they were moving in together at the time of the second interview. Other relationships were of shorter duration and several were over when they were interviewed again. Whether their primary partner was male or female, the participants all had sex with gay men outside their relationships. Three claimed that they always used condoms for intercourse and the remaining 11 admitted that despite knowing about the risk of HIV, they did not always use condoms.

The reasons for not using condoms in sexual situations were complex and usually not attributable to simple answers. However, several themes emerged from the interviews as being important consequences of the transition into the gay community that impacted how sex and safety were negotiated. These were not mutually exclusive explanations for why condoms were not used. They were aspects of risk that were particular to the experience of being a transman in the gay community. First discussed is the unfamiliarity many had with the social/sexual workings of the gay community. The next section examines dynamics between gay nontransmen and transmen that resulted in an increased risk for some. These included the need for validation coupled with the difficulty of disclosure, and the dynamics of sex and power between the transman and biologically normative gay man. That is followed by a discussion of several assumptions made by both nontransmen and transmen regarding risk. Testosterone impacted risk in several ways that will be discussed. Finally, sex work emerged as a significant factor for several of the participants.

An Unfamiliar Community

The transition into the gay community was a goal that many of the participants wanted and eventually did achieve. All of the participants were new to the prospect of living as gay men within a gay social world, and were trying to understand the rules and codes of sexual behavior, and how to negotiate safety. However, it was those who had little or no experience with the gay, lesbian or queer communities who had the least amount of familiarity with gay culture prior to transitioning. Three were married to heterosexual men and some, like Ricardo, experienced limited contact with gay men. He found that transitioning presented risks that he had never had to consider before:

> Well I've had to think about it. See, I never had to think about it before, I was married, I was heterosexual. I didn't have sex much before marriage; I was asexual for a long time. And then when I was promiscuous, it was pretty protected, but then I was married, and you don't have to worry about it. So this was really the first time I'm really afraid, or you know, have concern, about getting it. And so I think I can be lackadaisical about that. Because I wasn't around when the whole AIDS thing happened, you know, I was doing whatever. I knew about it but I wasn't involved, or didn't know people. It didn't impact upon my life. I knew one guy at work that died of it, but, it was just kinda "Oh, that's what gay men do," you know. Never dreaming I'd be one.

Ricardo's familiarity and experience was with a heterosexual social world and he found himself a gay man at age 45. Four of the participants had been lesbian identified prior to becoming gay men, and like Ricardo, the idea that they would have to protect themselves from the possibilities of HIV or STDs was not a part of their previous experience. It was an abstract notion that had never impacted their lives before and they had become real. Ben, who worked at a sex club that catered to both nontrans gay men and transmen, commented about the risk he sometimes saw transmen engaged in:

> I know quite a few guys that definitely don't want to talk about it, either because they don't want to be like standing out. But they don't know that much about having sex with guys, and what's okay, what's not okay. And that are just happy to have sex with guys, no matter what. And they don't really know much about safe sex, or educate themselves because they don't want to be outed as not knowing so much. I see that.

Even familiarity with gay men did not necessarily impart the practical knowledge of how to successfully maneuver through the social and sexual territory of the gay community. Leroy was a fully passing sexually active gay man within two or three months of transitioning in his mid-twenties, but he was lacking the experience of what it means to be part of the community. That lack of experience led, at times, to situations of risk:

> L: I think there are things that gay men, that we deal with that—and it takes a while. But after a while, you get tired. You get tired of using condoms. You start to realize that every other person you talk to has HIV. There's a lot of substance use. I don't think I was prepared for that, no.
>
> SR: Was it difficult to keep safe?
>
> L: Oh yeah, totally. I think I've gotten to a point now where I am very conscious about when I have sex with people that aren't—that are random hook-ups or that are just kind of casual sex partners, I'm very conscious about when I have sex with them. Because what I've found for myself is that if I'm really sad—I don't ever drink any more, when I'm really sad, because that is just like a recipe for disaster where I'm concerned. I won't have sex with most people when I'm sad, because I feel like I make bad choices. I don't have the energy to fight the things that I don't want to fight, you know. And I won't have sex when I'm with a casual hook-up when I've had more than two drinks. I mean I've given plenty of people blow jobs in that state, but I would never have penetrative sex. So in terms of STDs, that's incredibly risky, you know, and I've been pretty freaking lucky.

LeRoy was able to learn through trial and error how to minimize his risk. He learned that the sexual hunting ground of the gay bar could be a dangerous place with its emphasis on alcohol, especially if he was in a depressed mood. He also learned that if he was under the influence with a partner in which he did not have complete trust, oral sex was a much safer option than trying to negotiate condoms with penetrative sex. None of the participants used condoms when performing oral sex on nontrans men. Several of the participants reported that they had had sex partners that they knew to be HIV positive and others needed to seek post exposure prophylaxis (PEP) due to HIV risk. Interestingly, the majority of the participants reported that they were involved in the S & M, or leather community, before they transitioned. This was equally divided among those who identified as lesbian or heterosexual prior to transition. Most retained the interest in S & M after transition, though two who were gay identified stated that they had left it behind.

Dynamics of Acceptance and Rejection

The process of transition created a need in all of the participants for validation of their new male identities. Personal validation is important for all people, but for the transmen it was a necessity. Their previous lives and identities as women were gone and the new identity required reinforcement and feedback. For the majority who identified as gay men, an important source of validation came from the sexual attention of gay men. However, the phallocentric attitude that was omnipresent throughout much of the gay community made acceptance of a man without a penis a major challenge. Passing well conferred some social acceptance in gay society, often with an accompanying invisibility with regard to ones transgender status. However, passing was no guarantee, on the interpersonal level, of success in finding sexual partners, or sexual partners who would

become longtime partners. The point at which, in the course of transition, the participants passed as male was different in each circumstance based upon, among other things, the person's genetics and dosage of testosterone (Gorton, Buth, & Spade, 2005).

It was early in transition that the question of whether or not one passed was most uncertain. That determination came from the response of others to one's gender presentation. Some participants reported difficulty in knowing how others perceived them, or where to locate themselves apropos of gender. Carl told of a man he met on the Internet for sex whose perception was that he was a pretty 14-year-old boy when in reality he was 24 years old. Despite the fact that this perception was far from affirming the identity Carl was striving for, the feedback he received helped him to understand how others were reading him. He eventually felt the need to be perceived as older which reinforced his continued use of testosterone as he carried on with his transition.

After the participants felt that they were passing, there was no question as to whether a gay or straight man was preferable. Sex with straight men was out of the question since they would have no attraction for a passing transman. After he starting transitioning, Cheyenne had partners who were trans women, nontranswomen, transmen, nontrans gay and bisexual men, but never a straight man:

> I've had a relationship with an M-to-F, maybe five years ago, for maybe a year and a half. And I've dated other F-to-M guys. But casual sex primarily with men that are either gay men or bisexual men. I never really had someone that was a straight guy. I mean I feel like I'm too much of a dude for a straight guy.

LeRoy quite vividly recounted what it was like for him to realize that he was passing very early in his transition:

> But I think part of it, too, is in the beginning of my transition, as I passed very early on, I had been wanting to be with men, as a gay man for so long that all of a sudden, I had this freedom. And at the time, non-monogamous or multiple sex partners was interesting, because it's like trying on new outfits. It's like, an adolescence that I never had. So, that combined with libido changes because of testosterone.

While exploring the sexual possibilities that had opened up might have seemed like trying on new outfits, that change of clothes, unfortunately, had the potential to be dangerous. The need for validation, combined with new possibilities, and the hypersexuality of testosterone (Gorton et al., 2005) all worked to create a situation with great potential for high risk.

At times, the need for validation compromised the determination to maintain sexual safety. Many of the participants reported situations when the desire for validation through sex with a gay man led them to forgo the condom that they had intended to use. For many of the participants, the validation received by being pursued for sex trumped all other considerations. Ricardo, who was just one year into his transition, spoke of how important validation was and how achieving it could put one at risk:

> I'm still in that learning phase of who I'm attracted to. And I have to say that the men I've been with I was wanting more sexual validation than really attracted to them. But the sexual validation really takes priority sometimes. I'm learning that "Hm, I'm compromising myself." I'm learning to say that, am I compromising myself just to get validation sexually, or you know, is there an attraction there.

Validation of identity was not only imparted by having sex with a gay man but also in some extreme cases by becoming part of the gay community by acquiring HIV. Two of the participants reported that this desire was so overwhelming that at one point in their post-transition lives that they tried to become HIV positive so that they could feel an even greater affinity with the community. Cheyenne craved that belonging so much that he willingly put himself at risk:

> And there was something that happened one time, I felt like everybody around me was positive. I don't know, it just was like my experience at the time, it's not necessarily my experience right now. But at the time I felt I was already different and already left out, and I know I'm not the only one that felt that way. It felt like I already had a disease with my blood that could put people at risk, you know, with having hepatitis. But it wasn't really giving me a sense of belonging, or giving me free acupuncture, free massage, free reiki, free housing, free this and that. Although now there's not so much of that. But I was getting off on putting myself at risk, you know. And I was even telling people I was positive so they wouldn't have issues about being with me sexually.

Though all ten stated that the feeling of belonging was something that was important and really mattered to them, only two reported willful actions of intentional risk in order to become more integrated into the gay community.

The desire for validation through sex was complicated by the dilemma of when to disclose one's transgender status. The participants were not in agreement with regard to when disclosure should take place or how to do it. They all agreed that disclosure was a very awkward proposition that they fumbled through. It was stated that if there was going

to be a sexual encounter, then disclosure would be appropriate; however many told of sexual encounters where disclosure did not take place. For example, it was possible to give another fellow oral sex and keep their pants on and no one would be the wiser for it. Cheyenne related a story of a time when he wanted both sex and drugs and did not disclose:

> Okay, one time, well I kinda relapsed on meth, and I wanted to use, so I went online, looking for drugs, mainly. I wanted to get high, so I didn't want to tell the guy that I was an F-to-M, because I wanted to get high. I was drug-motivated. So I actually got there, and he was like "Do you want to take a shower?" And I didn't want to get naked yet, because I was being selfish, I mean, I wanted to get high. So I was afraid of being rejected.
>
> And it was a good thing that I did that, because when we did get high, and when he found out, he was like "Ooh, not really into it, sorry, so-". I was like "At least I got high."

Cheyenne's story also brought to light some of the multiple risk factors that were seen among the participants. Several disclosed histories of drug and alcohol abuse.

While the avoidance of disclosing held a certain appeal, there was always the danger of discovery that presented the risk of not just rejection but possible violence as well. None of the participants reported any violence from such a discovery, but they were always aware of the potential. The right timing was essential for disclosure. Keith related his own idea regarding when that should be:

> Actually, I usually don't disclose that I'm trans unless I'm about to get into somebody's pants. Or think that I'm going to. It depends. If I'm just at a sex club,

> then I wear a jockstrap, I don't disclose. I don't feel that it's really relevant. If it looks like there's dating potential, or whatever, then it's a conversation that's had, and that's actually before it gets physical. But if it seems like there definitely is interest, and usually it's not the first conversation, but a second conversation or what have you.

Another option was to disclose right up front so there was no doubt as to the transman's status. This immediate disclosure was employed in two ways that many of the transmen used to meet their partners. The first was via the Internet. Personal ads and profiles were the perfect means for disclosure without facing the emotional repercussions. All of the participants, with the exception of one who did not own a computer, reported that they used this method for casual hooking up. However, even this impersonal method was not completely without risk. Some told of nasty postings on their profile from rather mean spirited gay men. The other way to disclose up front was the non-verbal method. This meant exposing the naked truth right from the start. This was done in sex clubs where the patrons were all expected to check their clothes. Participants mentioned that there was one sex club in San Francisco that had the reputation as a welcoming venue for both nontrans gay men and gay transmen. The official policy of the club was to strictly enforce a condom only rule for penetrative sex. All reported that they used condoms when they were there.

Besides the need for validation, the power dynamic between trans and nontransmen also impacted condom use. This power dynamic was determined by how the individuals involved reacted to the non-normative body of the transman. Sam, who at different times in his life, was both a female and transmale sex worker, offered this

explanation for what he referred to as power positioning. This was where a transman might believe that he owed a debt of not using a condom to a biologically normative male:

> S: I mean I think that that is true, obviously bottoming is a riskier behavior. But I think that where trans guys have the most risk of STIs comes from power positioning.
>
> SR: Tell me what you mean by that.
>
> S: I think that there is this dynamic of a lot of trans guys enter gay men's worlds, like post transition. And it's something that they are going into very rapidly, and without maybe some of the understandings of like, what's expected, or like, what are sexual health practices and all these things. And they're also coming at it from this position of insecurity of identity. And I've definitely heard people say, like-I have a friend who I'm talking to at the moment about his unsafe sex practices. And he says he'll go home with a guy and then he'll put a condom on and they get soft. And he's worried that the reason they're getting soft is because he's trans. And then he feels like he has a debt to let them not use a condom because of his non-normative body. So I think that-because condoms are-even if you're having sex with an HIV-positive person, if you're using condoms, it's a very low risk of transmission. It's more about the emotional reasons that people don't use condoms when they're trans.

Several of the participants spoke about feeling guilty if their partner had erectile dysfunction and as a result, did not use a condom for sex. Certainly dynamics of unequal power between the nontrans gay male and the transman existed. In most cases the power

was wielded by the person who possessed the penis. However, this was not always the case. Whereas most stated that they were happy with the bottom role during sex, several reported that they enjoyed switching with the use of a dildo. Ski, who had sex partners that were both gay men and women, claimed that he was always put in the top role despite the fact that he wanted to try being bottom at some point. None of his partners allowed this to happen. Since all penetration was done with a dildo, this was a strategic positioning that resulted in no conceivable risk for either party.

Assumptions Regarding Transmen, Their Partners, and Risk

Safety in a sexual encounter required that both individuals understood the risk involved and were in agreement with a plan for reducing it. Therefore, another important aspect of risk was assumptions made on the part of both the transman and his nontrans partner. Just as some transmen were lacking the skills necessary to negotiate safety with nontrans gay men, participants reported that, from their experience, there were gay men who were lacking information regarding the possibility of risk with, and to, transmen.

Since none of the participants had phalloplasty, those who had sex with nontrans gay men were usually the bottom, or the receptive role, for anal or vaginal sex. Some preferred vaginal sex, others anal, and some enjoyed both for different reasons. The participants spoke about their partner's reaction to them. For many nontrans gay men, vaginal sex was something they had abandoned years earlier, if they had ever engaged in it at all. Sometimes when the genitals involved were unfamiliar, the awkwardness resulted in silence when safety should have been discussed. At other times, as Hank told it, incorrect assumptions prevented safety from being considered:

> Once gay men understand that you have female anatomy, they feel like it's less risky for them. That maybe they don't need a condom for whatever they're doing, for whatever both of you are doing. Or that… because their risk is lessened by being with-I don't know if it's the perception of somebody who hasn't been a gay man for quite as long, or just that those body parts don't transmit AIDS and STDs-in the same way. I talked to a few people who have had a similar experience as bottoms. And the top isn't going to contract- To say that the person on the receiving end, whether it's anal or vaginal sex, isn't going to transmit anything to the top, and if the top's clean, then it's all safe. Which of course isn't the case, but I mean, statistically there's probably something to that. Or maybe not at all.

Hank was correct that statistically it is less likely for the bottom in sex to transmit HIV or any STDs. However, that does not mean it cannot occur and certainly the presence of an STD in either partner could facilitate HIV transmission either way (Hart & Elford, 2010). It has been reported that some nontrans gay men use strategic positioning as a form of risk reduction (Elford, 2006). This means that if the HIV positive or more risky sex partner takes the bottom role, then it is assumed that sex without a condom will not present a risk to the top. However, transmen, except in rare cases, are by necessity, in the bottom role and often faced with a situation where they are being convinced to forgo the condom since, it is supposed, transmen are not as likely to be HIV positive as nontrans gay men. If a transman were to have unprotected sex with multiple nontrans men, and several of the participants stated that they had, the possibility would exist for the presence of an STD or HIV, and transmission to the top would be possible. Also, the novelty for

many nontrans gay men of having sex with a transman led to taking greater risk than was originally intended by the transman. Many stated that they would have been quite content to have non-penetrative sex but that all too often vaginal or anal sex was all that their partner wanted.

Transmen also spoke of assumptions that they made that led them to justify forgoing condoms in certain encounters. Ben reported that before he believed that he was passing well, he assumed that the men who were attracted to him were straight or perhaps bisexual. He went on to assume that they also would not pose a risk for HIV:

> And what I noticed was that when I was looking for men on Internet Site, very few gay men would respond to me, it was mostly straight men and bi men. And I think this was because I was being perceived as some butch dyke. I just assumed that if somebody was interested in me, because I was F-to-M, it meant that they were straight. Or bi, but really they were primarily attracted to women. They were also into F-to-Ms, but didn't really have that much F-to-M experience. So I did have this assumption that is now being challenged, that men who are attracted to me were actually not gay. And I think perhaps because of that there were some times where it felt easier to take certain risk.

Ben pointed out that these assumptions were made early in transition when he was unsure of how well he was passing. If a man was attracted to him, then he could not be a gay man, and therefore he was lower risk and the need for safety in sex was less of an imperative. Ben went on to state why, in early transition, it was easy to convince oneself to trust the assumptions:

> Both of those are assumptions and misperceptions, which I intellectually know, but when you are also really horny, if you're not really having enough sex, if you're not really getting it on an as regular a basis, then when you do hook up, then you're extra horny, and you happen to crave cum. And you have this misperception, it just makes it so much easier to bareback. So yeah, I would do that.

Sometimes assumptions were based on fragments of factual information that were used to defend rather unsafe practices. While it is true that receptive anal intercourse is the primary risk for gay men, that does not mean that vaginal sex for transmen was a safe activity. However, as Keith recounted, that assumption was made:

> I was using the front a lot, because you know, you don't have to clean, it's just easier, there was also this level of like, okay, I'm not at risk. Because the higher risk is the anal.

Testosterone And Changed Bodies

While the gay community was often unfamiliar territory, transition with testosterone also brought about a changed body that could be just as unfamiliar and a source of concern with regard to sex and safety. Testosterone use resulted in a number of reversible and irreversible changes. These ranged from increased libido, acne, emotional changes, and increased appetite, to physical changes such as increased facial and body hair, increased muscle mass, and clitoromegaly. Genital changes most concerned the participants with regard to safety. Some reported that they experienced vaginal dryness that predisposed them to bleeding during intercourse. Mick, the only participant who was

HIV positive, was worried about whether the rules of safety would be changed with his changed genitals:

> Finding out that I was HIV positive has taken off -- I mean, I'm trying to get statistics from anybody. I'm in the middle of writing this freaking thing on HIV prevention modules, I can't get a good answer from anybody on whether there's any good way for trans guys to have their cock sucked unless you're using a dental dam in which case it doesn't work the same way, as it's working on a female body. Because when my clit was only this big, licking or even light sucking that makes sense. But when I got this much, like that's -- that doesn't make sense for a dental dam anymore. There's no devices out there on the market other than wearing slightly baggy latex hot pants. That's about it. That's what we got. And so, yeah a lot of options have been taken away from me.

Mick was concerned that the large size of his transformed clitoris and its close proximity to infectious vaginal fluids would present a greater risk than he was willing to subject his partners to. He was also frustrated that he could get no information specific to trans bodies and risk.

Universally, the participants reported that the use of testosterone resulted in a period of second adolescence that was characterized by a remarkable hypersexuality. Some stated this period lasted for only a few months while others claimed that it lasted for more than a year. Cheyenne recounted his overwhelming sexual urges:

> It was, wow. It was like, a teenager all over again, and I felt—I had all this energy and all the, and my appetite went through the roof, and I was hypersexual, I had to like jerk off like five times a day, I mean it was like I had all this energy. I was

> acting out sexually. If I have a lot of testosterone, I have a harder time controlling my sexual impulses. I also find that I am more impatient, and I get agitated more, and I have a hard time, a little bit, with my roommate, because he doesn't want to be sexual. And so it just complicates things if I have a lot of testosterone, And then I get more short-tempered.

While all experienced the feeling of hypersexuality, not all acted on it. However several of the participants believed that the use of testosterone contributed to situations of hooking up with men and agreeing not to use condoms. Also access to testosterone was problematic for some. In San Francisco testosterone is fairly easy to access through several low cost transgender clinics. However, some participants, such as Ski, began their transition outside of San Francisco and due to economic and logistical reasons, bought testosterone and needles on the black market.

Sex Work

Five of the participants stated that they had been involved in sex work. Three of them were engaged in sex work before and during transition and the other two began the work after they transitioned. Especially for those who began after transition, part of the motivation was to see if they passed well enough to attract gay men as clients. Another motivation was to earn enough money to pay for the top surgery that was not covered by their health plans. While four of the five reported that they always used condoms with their clients, one of them related the story of how he never used a condom with the one client that he knew to be HIV positive. Sam, who had been doing sex work for more than seven years and was still engaged in it, made the comment that even though he could and

did demand condom use from his clients, this was not necessarily an easy thing to do and it required experience and assertiveness.

LeRoy became a sex worker for about a year shortly after he transitioned. The reason he stated for doing this was a dire economic situation at the time. He also admitted that he romanticized the idea of being a sex worker. He claimed to have used condoms with all of his clients except for one that he knew to be HIV positive. He described how this came about:

> It just started out, like we didn't use condoms. And I think, to be honest with you, there's this—I mean, I don't know. There was a lot of power dynamics happening there, which is like, he's a biological man, I'm a trans guy. He's HIV positive, I'm HIV negative. I'm a sex worker and he's paying me to have sex. So, I mean I think the biggest thing in there is the being paid to have sex. And there was—I don't know, I just was afraid to ask him to use a condom. I denied that it was as risky as it was, in my head, to make it okay.

Interestingly, LeRoy mentioned several aspects of unequal power between him and his HIV positive client, all of which ascribed power to the client. Several participants reported a history of sex work, but none with the exception of LeRoy reported any difficulty in demanding that a condom be used for intercourse. Sex work was a new experience for LeRoy and he had not yet learned how to advocate for his safety needs. It was after this episode that he gave up sex work completely.

Discussion

This study identified and described significant aspects of risk that existed for the transmen participants. Fourteen of the 17 reported that they identified as gay, bisexual, or

queer and they had gay men as sex partners. To a great extent, studies that have focused on male-to-female transgender individuals, or transwomen, have overshadowed those concerning the experiences of transmen. As a result, comparatively little data exists concerning transmen and their distinct risks for HIV and STDs (Herbst et al., 2008). Even though the actual prevalence of HIV among transmen has been estimated to be as low as 0-3% in some studies (Clements-Nolle et al., 2001; Herbst et al., 2008), a low prevalence does not necessarily indicate low risk or the lack of potential for a rising incidence. The data regarding HIV among transmen is sparse and problematic. Many clinics that engage in testing do not have the means to accurately indicate that a patient is transgender. Often if a category for transgender is used, it is inclusive of both transmen and transwomen since the assumption is that transwomen bear all the risk and the population of transmen is neither at significant risk nor in need of prevention services. However, many transmen pass to such an extent as to be undetected by clinic staff and, in effect, have been invisible to adequate assessment. It is conceivable that HIV prevalence and associated risk behaviors have been underreported as a result.

By becoming part of the gay community, the transmen assumed the risk inherent in the population. This meant that not only did their social milieu change but also the consequences of risky behavior had altered dramatically. A recent report estimated HIV prevalence among MSM in San Francisco as 24.3% (Scheer et al., 2008) and characterized HIV as hyperendemic in the gay community. Therefore, the probability of an MSM living in San Francisco becoming infected with HIV in his lifetime is extremely high. In fact, at the 2010 National STD Prevention Conference, the Centers for Disease Control and Prevention reported that gay men are 44 times more likely to acquire HIV

than other men (Roehr, 2010). This raises the question as to whether that statistic applies equally to gay transmen. While the participants demonstrated aspects of risk that were particular to their transgender status, they also demonstrated many of the same attitudes and adaptations that have been documented in the larger gay community.

During the course of the epidemic, phenomena such as safe sex fatigue and treatment optimism adversely impacted the risk reduction messages of public health campaigns and led to an attitude of indifference with regard to safety among some gay men (Ostrow et al., 2008; Schwarcz et al., 2007). MSM developed a number of strategies in order to attempt to reduce the chances of becoming infected while opting not to use condoms with their partners. These included such adaptations as serosorting, or choosing sex partners who presumably have the same HIV status (Osmond, Pollack, Paul, & Catania, 2007; Rowniak, 2009; Truong et al., 2006), and strategic positioning, or taking the role of top in anal sex with the hope that it will prevent transmission from an infected bottom (Elford, 2006; Hart & Elford, 2010).

When LeRoy voiced the sentiment from his position as a member of the gay community that “you get tired of using condoms”, he was echoing the same language of safe sex fatigue that had been attributed to nontrans gay men. The transmen who had steady partners were engaging in the same protective strategy of serosorting as many in the larger gay community by choosing not to use condoms with partners whose HIV status was presumably negative. One important difference was that while nontrans gay men had the option of strategic positioning, this was not a possibility for most of the participants. Another phenomenon that was reported in a rather sensationalistic manner several years ago was that of gay “bug chasers” who tried to become infected with HIV

(Grov & Parsons, 2006). That term could certainly be used to describe the behavior of the two transmen who attempted to become infected.

Living within the gay social/sexual community placed the participants in a context of risk for infection, and it was the actual behavior that constituted the risk. Specifically, that meant multiple partners, or a single partner, should he be HIV-infected, and inconsistent condom use. The transmen were engaged in the same behavior as all sexually active gay men, however, their circumstances were in many ways distinct. Transition determined these distinctions. These included the unfamiliar nature of the gay community for those who transitioned into a new sex and sexual orientation, the nature of the dynamics between nontrans gay men and transmen regarding validation and rejection, incorrect assumptions concerning safety and risk, and the effects of testosterone on sex drive and the physical body. Sex work also played in role in the risk of some transmen.

Gay men, through their attention and interest had the power to determine how well the transman passed and could be the source of validation of their status, or the source of rejection. The desire for this validation at times led to the abandonment of all intentions to keep safe. The fact that all of the participants found the disclosure of their status to be an awkward proposition was related to some extent to the belief that disclosure would most likely result in rejection, a devastating possibility. This was one example of the unequal power dynamic that existed between the nontransman and the transman. As Sam suggested, this perceived inequality due to different body parts felt like a debt that the transman owed that was paid by not insisting on the use of condoms. This was compounded by the lack of negotiating skills that many felt as a result of

transitioning into an unfamiliar community in addition to the insecurity regarding disclosure.

The specific physiological circumstances of the transmen contributed to their distinct risks. One of the participants had a failed testicular implantation and none of the others had any bottom surgery, therefore, most found that there was little choice regarding sexual position. Though some used dildos to penetrate partners, most reported that they took a bottom position for both biological and preferential reasons. This meant that the transmen tended to be in the position of higher risk. While some stated a preference for vaginal sex, and others for anal sex, most engaged in both types depending on the partner and circumstances. Having vaginal intercourse possibly presented a unique risk itself. Namaste (1999) reported that some transmen believed that vaginal sex was much less risky than anal sex; therefore it was not as necessary to use a condom for vaginal sex. Assumptions of lower risk with regard to vaginal sex were also seen in this study. Some of the participants claimed that the use of testosterone caused increased vaginal dryness and friability. Certainly any such physical changes in the vagina would increase the possible risk of unprotected sex. Likewise, there was a lack of information regarding changed genitals and how they could place the transmen or their partners at increased risk. Also, even though the use of testosterone caused a cessation of menses and pregnancy was very unlikely, testosterone was not a guaranteed form of birth control. None of the participants were using any contraceptive other than condoms, which meant there was a small risk of pregnancy when they were not used. There is a need for further study of the effects of testosterone on the vaginal mucosa especially with regard to the

beliefs of some transmen that vaginal sex was a lower risk, and perhaps an acceptable risk, when compared to anal sex.

Sex work was different from the other aspects of risk. It was not particular to the process of transition nor was it something that occurred necessarily after transition. A strikingly high number of the participants were engaged in sex work and for those who were less experienced, it was an area of real risk. One reason given for engaging in sex work was the need for money for top surgery that was extremely expensive and not covered by most health plans. It was also possible that the need for validation of male status played in role in the choice of sex work for two participants who began after transition. The risk that sex work poses to transwomen has been documented by several studies (Herbst et al., 2008) but more data regarding the prevalence and reasons for sex work among transmen is needed.

These distinct aspects of risk operating singly or in combination, impacted and modified the inherent risk of contracting HIV by being part of the gay community. However, simply needing validation through sex, or the presence of any of the other factors, did not mean that safety was always compromised. Various influences contributed to the specific vulnerability of the participants and allowed for the risk to occur. For example, those who were earlier in the process of transition had less practical experience and were more likely to be overwhelmed by the second adolescence that testosterone and the new possibilities of sexuality made available. Also drugs and alcohol were responsible for increased vulnerability in social and sexual situations. The two transmen who tried to become infected suggested that possibly depression or other

psychological problems that were of a longer duration also played a contributing role in the risk.

Men who engage in the process of coming out enter the gay community and experience both an emotional and a sexual liberation. This is a period for many to experience the sexual adolescence that was never the way it should have been due to living a closeted life. Often, sexual acting out and experimentation follow. This is one reason why young gay men are especially at high risk for HIV (Mustanski, Garofalo, Herrick, & Donenberg, 2007). For the transmen, this period of adolescence was compounded by several factors. The transition into becoming a gay man allowed for sexual possibilities that had not previously been explored. The experimentation was fueled by testosterone that was universally reported as causing hypersexual behavior.

Those transmen who were earlier in their transition had less opportunity to learn how to adjust to the new community. They arrived with a newly activated sex drive but without the practical knowledge of how to negotiate their own safety. For many, not only was the gay community foreign but it was also unexpected. Those who were previously lesbian anticipated continuing with women as partners, and those who had male partners were familiar with heterosexual men, not gay men and the culture of gay sexuality. However, this was something that, over time, could be learned, but that involved a period where poor judgment and mistakes were possible. It has been posited that community integration and involvement could be a protective factor with regard to high-risk behavior (Ramirez-Valles, 2002). However, some studies have suggested that gay community integration might be associated with increased risk of HIV infection (Fergus, Lewis, Darbes, & Butterfield, 2005; Martin, Pryce, & Leeper, 2005). It is interesting to note that

many of the participants had been, and continued to be, involved with the S & M community. The gay men's S & M community is becoming a significant point of integration of transmen into the larger gay community. This has involved the recent appointments of several transmen to prominent leathermen titles; positions that had previously been restricted to gay nontransmen only (Brogan, 2010). It will be important to examine further how this may impact the integration of transmen into the gay community and how that affects risk and HIV incidence. It also could prove valuable to understand any correlation between being a transman and involvement in the S & M community.

There are several implications from this study for health providers who work with transmen, before or after transition. It should be assumed that many transmen will transition into the gay community, whether or not they anticipate it. Ongoing risk assessments would benefit from discussions that go beyond simply the importance of condom use, but explore those unique aspects of risk that the transman will most likely face. The incorrect assumptions that are often shared by transmen and their nontrans partners should be addressed. These include the assumptions that transmen are neither at risk nor pose a risk for HIV, that the partners of transmen are not a source of risk since they must be heterosexual, and that vaginal intercourse is a safe substitute for anal intercourse. The hypersexuality and physical changes brought on by testosterone need to be discussed prior to beginning its use and revisited regularly. Sex work was an option for obtaining money for surgery that was not covered by health plans and could be a source of great risk for those not adept at demanding safety from their clients. Part of the

routine sex history should include questions regarding sex work. Routine testing for HIV, STDs, and hepatitis is essential.

Often health clinics offer more barriers to care than access for transmen. There are ways to create a welcoming environment within a clinic. It is important that at a minimum, the correct pronoun be used when transmen are addressed. Several spoke with disdain for medical practitioners they had encountered who refused to grant them the courtesy of calling them men. Not only is the correct pronoun essential, but so too is a chart with the new name and sex of the transman. It is the antithesis of validation to be presenting as a male with a full beard at a clinic and then to be addressed in a female name that is associated with an identity that no longer exists. For most of the participants, the last thing in their lives to transition was their ID that contained their female name and sex. Recognition of this and the usage of the preferred name and sex will go a long way to making a clinic a place for health care and not a site of anguish and struggle that is often avoided.

It was also difficult for many of the transmen to discuss their own body parts using the words that they had grown up with and were therefore associated with their previous gender identity. This was not a universal situation but one in which there was a wide variability in comfort. For example, many of the transmen, especially those who had been involved with sex education throughout their lives, expressed no discomfort in using the term “vagina”, while others insisted upon using more vague terms like “hole” and “stuff”, or “junk”. This discomfort also carried over to gynecological medical procedures such as PAP smears and pelvic exams. Part of the discomfort was based on the fact that in order to get these procedures done meant attending women’s clinics where they would

stand out as the only male identified person present. Again, this tended to be demoralizing when validation was what was needed. The dysphoria that, for some, was generated by the vagina led to the avoidance of language and care. Any clinician who works with transmen would benefit by negotiating with the patient just how body parts should be referred to, which may help begin the discussion of health maintenance.

Limitations of this study are a result of the number and type of participants. A small sample of 17 individuals cannot be used to generalize to the unknown number of transmen in the United States. The majority of the participants were transmen who had sex with men. Recruitment in a city other than San Francisco could result in a majority who identified as heterosexual and had biological females as partners. None of the participants had phalloplasty. Perhaps the experience of transmen with phalloplasty within the gay community is very different. Also the criteria for this study included the stipulation of a transition using testosterone for at least one year. Not all individuals who identify as transgendered choose to use hormones for transition or even to transition at all. It is likely that those people who do not use hormones would have a very different experience. Also, all of these participants lived in an urban environment. The experience of those who live in a rural or suburban area could also be very different. A greater variety in racial and economic background of the participants would provide a broader understanding of the phenomenon. It would also be beneficial to understand the experience of the partners of transmen.

Conclusion

Despite the fact that the reported HIV prevalence for transmen is very low, this study suggests that there exists among transmen who have sex with men (TMSM) a risk

that is comparable with nontrans gay men. It is also possible that being a transman within the gay community confers an even greater vulnerability than experienced by other members of the gay community. Not only do the risks of living in a high prevalence community that has suffered from the damage of HIV for three decades exist, but also as transmen newly situated within the gay community, there are particular risks as a consequence of transition. Transmen are still a relatively new phenomenon within the gay community. One important challenge is as they become more visible and accepted, without specifically focused interventions, the incidence of HIV could approach that of the rest of the community.

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Conclusion

This dissertation began with an examination of the changed climate of the gay community with regard to attitudes and practices relevant to HIV prevention and risk. Early in the epidemic the community responded by creating and adopting safe sex practices that resulted in decreasing infection rates. The reversal of the trend that began in the late 1990s corresponded with the advent of the improved treatments that came to be known as highly active antiretroviral therapy (HAART). The subsequent relaxation of previously valued safe sex practices was referred to as safe sex fatigue (Ostrow et al., 2008; Rowniak, 2009; Schwarcz et al., 2007). It was fueled by the growing treatment optimism that much of the community appeared to share (Scheer et al., 2008). Adaptations to over 20 years of the epidemic included serosorting and strategic positioning (Osmond, Pollack, Paul, & Catania, 2007; Truong et al., 2006). However, the effectiveness of these strategies is dependant upon the accuracy of assumptions made by both, or all, of the participants involved.

HIV in the gay community in San Francisco is currently hyperendemic (Scheer et al., 2008). The chance that anyone entering the community will become infected with HIV is unacceptably high. However, the types of people who comprise what we have known as the gay community has changed since the epidemic began. My clinical practice introduced me to the growing presence of transmen who identified as gay men. This led to the qualitative study “Sexual Identity, Risk, and Behavior Among Female-to-Male Transgender Persons”.

Two lines of inquiry were identified for the study. The first was to describe and understand the variability in sexual orientation and behavior among FTM before and after

transition and testosterone use. The second line of inquiry was to identify risk and understand how an FTM person's situatedness within the gay community affected HIV risk behavior. However, prior to answering those questions, it was necessary to understand and appreciate the experience of being a transman. It was from the stories of all of the participants that a trajectory for transition was developed. Despite the variation in experience among all of the participants, there was a commonality of phases that all went through, though each phase was characterized by individual variability.

Gender dysphoria marked the beginning of the transgender experience for all of the participants. For some, this was something they recalled from their earliest childhood memories, while others didn't experience the discomfort until adolescence began. Although considerable variability in the manifestations of gender dysphoria was evident, all participants reported some kind of gender discomfort. The early phase of the trajectory was characterized by a lack of vocabulary with which to put the cause of their essential discomfort into words. The absence of words or concepts to articulate what was happening to them resulted in a period of trying on different identities**.** Very important and pivotal for all participants was the eventual realization of being transgendered. The description from all was of a moment of revelation that was triggered by some external stimulus. Testosterone proved to be a key to transition and all required access to this key in order to realize transition. Using testosterone resulted in changed bodies that allowed for passing, which meant being seen or "read" by others as being male. The final phase of the trajectory was the condition of being gay or queer.

It was only after obtaining an understanding of the commonalities and differences of the trajectory that question of sexual orientation could be addressed. Of the 17

transmen who participated in this study, all but two stated that they had gay men as sexual partners after transitioning. All described themselves as either gay or queer. The participants, in general, shifted to a sexual preference for men; however, it was important to understand that there were differences with regard to their sexual orientation prior to transition. In contrast to the stereotype that transmen all came from the lesbian community, only seven of the participants had a lesbian identity prior to transition. Three of these seven retained their sexual attraction toward women. They constituted the **steadfast group**. The remaining four experienced an unexpected reorientation to a gay male identity. This was the **shifted group**. The other participants were either heterosexual or unsettled in identity prior to transition. Those who became gay identified were the **aligned group** and those who were very fluid in their orientation both before and after transition made up the **fluid group**.

While the naming of these groups did not radically impact consideration of risk, it served the purpose of understanding the spectrum of sexual orientation, identity, and behavior among transmen and worked to challenge some of the assumptions found in the literature .A primary assumption has been the notion that the gender dysphoria that resulted in a transgender identification was inextricably linked to a person's sexual orientation. From that idea developed the belief that there were two distinct subtypes of transgender who could be viewed through the lens of their immutable pre-transition sexuality, homosexual and nonhomosexual. Sexuality was therefore seen as a determinant of transgender development. However, in this study, sexuality was found to be an unpredictable outcome of transition, not a motivating factor for transition.

It has also, similarly, been believed that sexual orientation did not change in the course of transition. However, the reality for the participants in this study was more complex and was characterized by a great variability in sexual identity and expression. In part, this variation was due to the fact that, for the participant who had experienced gender dysphoria, the transition to being male opened up sexual possibilities that had been previously unavailable. Thus, transition allowed for the actualization of situated possibilities of sexuality.

After exploring the question of sexual orientation, it was then possible to analyze the data with regard to situated risk. This study demonstrated how the risks for HIV and STDs of transmen were, in part, a function of the fact that many were situated within the gay community and thus assumed the inherent risks of being gay men. However, there were also aspects of risk that were unique to the transmen because of their transgender status that increased their vulnerability.

Similar to the finding that increased HIV transmission in the gay community could be attributed to a relaxing of safe sex practices, many of the transmen reported that there were occasions where condoms were not used. However, all were aware of the seriousness of HIV and none voiced anything that resembled treatment optimism. Transmen, at times, assumed that if a man were interested in them, he was not really a gay man and therefore very unlikely to be infected. Likewise, it was reported by the participants that gay men often assumed that transmen were very low risk by virtue of the fact that they did not have a penis and they had been a part of gay community for a relatively short period of time.

There were also aspects of risk that were unique to transmen. This included the vagina itself and changes that might have occurred as a result of testosterone. Testosterone, also, often caused a hypersexuality that resulted in sexual risk taking. Other aspects of the transmen's situated risk were relevant to aspects of validation that gay male partners provided. This also was indicative of unequal power dynamics that some stated to be a reason for forgoing condoms. The gay community was also very unfamiliar territory for many of those who transitioned from very different communities. As a result many lacked the ability to negotiate for their own safety. Sex work and substance abuse also contributed to the overall risk.

The findings from this study have several direct implications for nurses and other health workers. Those who work with transmen prior to and during transition should be aware that their sexual orientation might change. Transmen need to be counseled regarding this as it could have consequences with regard to their current relationship and future plans. Also, it could be anticipated that a great number of transmen will transition into the gay community. It is essential to discuss all aspects of risk and to assess their familiarity and comfort with the gay community. Anticipatory guidance relevant to adjustment to their new situatedness is necessary. Ongoing discussions concerning risk should be conducted at regular intervals. These should include not only social and sexual activities, but also how testosterone has impacted the genitals and libido.

For those who encounter transmen in the context of being patients or clients for a short episode, it is important to not make any assumptions but to understand that there is a wide range of variability with regard to past experience and sexual orientation. For those working at an STD or HIV testing and prevention site, it is essential to understand

that some transmen are at a very high risk and many are new to the risk and do not necessarily have the skills they need to negotiate safety.

There are also implications that go beyond the limited scope of this study. The presence of increasing numbers of transgender persons within the gay community and society at large is an undeniable fact. It is incumbent upon all of us who work within the health systems to do all we can to increase our understanding of this stigmatized, often hated, and much ridiculed group of people and do what we can to ensure that they are welcomed and integrated into the social fabric. The nursing profession should advocate for social justice first and foremost. Unfortunately, when I began this project, fellow doctoral students informed me that this would be a difficult endeavor because, after all, "transgenders are all crazy". Needless to say, my experience was completely different. The transmen who participated in this study were, in general, extremely articulate, sensitive, and thoughtful men. They were all too aware of the prejudice and hatred around them. Especially noteworthy was the openness with which they spoke and how much they appreciated any work to disseminate their experience to others.

One problem that the transgender population has had with regard to the health professions, particularly nursing and medicine, is that they are often seen only within the context of pathology. The gatekeeper for transition is the health practitioner who holds the key to obtaining hormones. Yet even today, the only way a transgendered person can access this kind of care is to be labeled as having Gender Identity Disorder (GID) (Gorton, Buth, & Spade, 2005). In a process that is very much analogous to the way homosexuality was finally removed from stigma of being a mental illness, there is

movement to have GID removed from the DSM. Hopefully this will occur for the next revision of the DSM in 2012.

Certainly everyone who works within any community health system will encounter transgendered individuals, whether it is in the area of senior housing, primary care, substance abuse, youth clinics, or any other community-based service. A cursory analysis of these varied services would reveal that there exist numerous barriers to transgendered people. As a result, many of the transmen in this study reported that they only use these services “going stealth” so as to avoid any conflict or uncomfortable situations. This was done out of a perceived necessity, but it unfortunately meant a missed opportunity for the transman to receive the optimal care, and it also deprived the health workers a chance to be educated regarding the unique needs and experiences of transmen. Therefore, all health care providers should obtain a sexual history. This can then lead to questions of gender and gender identity. At times this can be awkward for a health care provider, but there are clues that can help with the questions. If the provider has any question of the gender of their patient, clarifying questions are in order. Also, all patients, regardless of the presenting problem, should be asked what medications they have been taking. Anyone who answers that they have been taking testosterone or other sex hormones provides the clinician an opportunity to ask more probing, but respectful, questions.

The barriers that exist are both interpersonal and institutional. As nurses and health care workers we can help to eliminate both types of barriers. One of the most important indicators of either respect or, conversely, disrespect, mentioned by the participants was the use of pronouns. Common sense should tell all people who work

with the public that one should address a person respectfully. However, there were many tales of doctors who refused to address transmen who passed completely and had full beards, as anything but “she”. Many members of the medical profession are justifiably known for their arrogance, but such behavior is beyond consideration as acceptable. The simple gesture of using the preferred pronoun can go far in making a transman feel welcomed instead of insulted. If the preferred pronoun is uncertain, the best option is to ask. Likewise, clinicians could show a respectful understanding of the experience of transmen by negotiating the names of body parts with them. Many expressed difficulty discussing the vagina, vaginal problems, or routine gynecological care with their clinician. Mutually agreeing upon the names of body parts can be a way to begin the often-avoided discussions of pelvic exams and PAP smears. Such interpersonal signs of respect and acceptance can contribute toward making a clinic or agency a welcoming service as opposed to a place to be avoided.

A significant interpersonal barrier is the lack of recognition of the possibility that one’s patient or client could have issues concerning their gender identity. One of the most salient aspects of the life stories of all of the participants was the fact that they all were aware of their gender dysphoria at an early age, usually before adolescence. Also, the majority struggled with substance abuse, self-abuse, or disciplinary problems because they did not fit in. Often these problems were manifest while the participants were in school and several left school because of these issues. Many spoke with counselors regarding their problems but they were never asked about gender identity issues despite the fact that there were clues in the participants’ behavior and appearance. An important implication for all who work with children is to keep gender identity issues in mind with

any child who might exhibit problems regarding self-care, socialization, or adjustment to school. It is also important to be able to refer the child to a specialist who can sensitively deal with the child's issues and not tell them simply to not make waves but to be like others.

Often institutions have systems in place that can act as barriers to transmen. Health clinics often demand that patients state their sex. Some transmen prefer to use a transgender category that many institutions do not offer. Others choose to identify as male but may find resistance from organizations that demand that only the sex of birth is accepted. Likewise, many clinics will only register a client with their legal name as it appears on their ID. Since the legal ID is often the last aspect of the transman to transition, a name that is completely at odds with their gender identity may follow them whenever they visit that clinic. Such practices are in place in many organizations simply because it was never considered that there would be patrons who would find such rules and regulations to be disrespectful. Any organization that wants to truly serve a transgender population should consider showing some flexibility in this regard.

Nurses and other health care providers can also be advocates to help change the policies of some of the medical clinics that provide transition services. Some operate using very strict criteria regarding who is allowed access to hormones and surgery and when it is available to them. Other clinics have relaxed many of the original rules of transition such as the requirement to live as the gender of identity for a specific period of time before hormones are prescribed. In a similar fashion, many transmen are not allowed to pursue top surgery without a signed letter from a psychiatrist or psychologist. In addition many health plans and health maintenance organizations provide coverage for

hormones for transition but do not cover any surgery, including top surgery. Instead of being the paternalistic gatekeepers that can grant access or just as easily deny it, a more healthful relationship would be one of cooperative guidance.

This dissertation identifies several areas for future research. There is a need for more research regarding the expected and unexpected effects of testosterone on both the bodies and minds of transmen. Related to this are an examination of the effects of testosterone on the vagina as well as the uterus and the current recommendations for a hysterectomy for transmen on testosterone. Since the study participants were limited to transmen who were using testosterone, it would prove valuable to understand the experience of transmen who choose not to use hormones. It is essential to conduct more research on ethnic minority transmen as well as those who live in rural areas of the country. These individuals could have a very different experience with regard to sexual orientation, risk, and relationships with their community and health care providers. Finally, much more research is needed regarding children who express gender dysphoria. While many will not be transgendered, there will be those who are. It will be essential to be able to predict who may be more likely to eventually seek transition and how best to provide it.

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Appendix A

University of California, San Francisco
Female-to-Male Transgender Study

Interview Guide

Introduction: Thank you very much for agreeing to participate in this study. As you know, I will be asking you questions related to being transgendered and how that may have had an impact your sexual identity and behavior. I will also be asking about testosterone use and how it might relate to sexuality.

1. Could you describe for me how you came to realize you were transgendered?
    -What happened as a result of your realization?
    -For each question I will use the following probes to elicit greater depth from the participant: Please give me an example of that. Tell me more about that.

2. I'm interested in exploring sexual orientation and sexual behavior before and after transitioning. How would you describe your sexual orientation and behavior prior to transitioning. Please begin with your earliest remembered feelings.
    -Various probings depending upon participant's response, for example had you been sexually active with males prior to using testosterone? Had you ever attended gay men's sex clubs?

3. Could you describe your feelings about your sexual orientation when you were coming out as FTM?
    -And what did you do about those feelings?

4. Could you tell me about how you began using testosterone?
    -How was it first provided for you? And now?

5. Could you tell me about any changes that occurred with your sexual feelings and/or behavior after you started using testosterone?

6. How would you describe your sexual orientation and behavior now? What do you attribute that to?
    -I expect a variety or responses from being in a monogamous relationship to engaging in activities at gay sex clubs. This area will be explored depending upon the responses.

7. I'd like to hear about your experience of becoming part of the gay community.
    -Can you tell me about your experience with finding sex partners?
    -Do you have a disclosure story?

8. Could you tell me about how you feel that the risk of HIV impacts upon you?
-Has this always been the case? How has this changed?

Narrative Strategy: Questions 6 & 7 both involve eliciting narratives from the participant.

The questions and probes will follow the format below:

-Can you tell about a time that you remember as especially meaningful with regard to:

A) Practicing safe sex
B) Practicing unsafe sex
C) Managing your identity, disclosing or not disclosing

Please tell me the story of what happened. It could be a memorable story because it was a

difficult situation or because you handled it very well.

The following probes will be used:

What happened- how the events played out
What is the setting or social context of this story, What events lead to the story
How did the situation unfold
What in this situation concerned or worried you
What did you do
What did you consider doing but rejected or were unable to do
What prevented you from doing that
What were your feelings as this was happening
Did you consider getting help or advice from others. Who.
How did you get other people involved or informed
What did they do that helped the situation

9. Could you tell me about any HIV prevention education that you've had? Do you feel it was adequate for your needs?
-How would you change this for other FTM?

10. Would you like to add anything more? Is there anything else that you think I should know? Do you have any questions for me?

Thank you very much for participating in this study.

Appendix B

University of California, San Francisco
Female-to-Male Transgender Study

Demographic Information Sheet

1. Age-_____

2. Ethnicity- White___
African American____
Hispanic____
Asian____
Other, please specify_____

3. Highest Education Completed-
Grade School____
High School_____
Some College_____
College Degree, please specify_____
Graduate School_____

4. Work Status-
Unemployed_____
Work Part Time_____
Work Full Time_____

5. Has primary medical care? _____
Where?_____

6. Amount of time in months participant has been taking testosterone-_____

7. Type of testosterone being taken-_____

8. Frequency-_____

_____

Appendix C

University of California, San Francisco
Female-to-Male Transgender Study

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Study Title: *Sexual Identity, Behavior, and Risk among Female-to-Male Transgender Persons who are currently using Testosterone*

This is a research study about sexual identity and behavior among female-to-male transgender persons who are using testosterone. The principal investigator for this study is William Holzemer, RN, PhD, FAAN, from the Department Community Health Care Systems. Stefan Rowniak, RN, MS, FNP, a doctoral student in the Department of Community Health Systems Nursing, is working with Dr. Holzemer as the Co-principal investigator on this research. Mr. Rowniak will explain this study to you. He is available to answer any questions about the study you might have.

Research studies include only people who choose to take part. Please take you time to make your decision about participating and discuss your decision with your family or friends if you wish. If you have any questions, you may ask the researchers.

You are being asked to take part in this study because you self-identify as a female-to male transgendered person who has been taking testosterone for at least one year.

Why is this study being done?
The purpose of this study is to better understand the sexual identity and behavior of female-to-male transgender persons and the possible implications these risks have for HIV or other sexually transmitted diseases.

How many people will take part in this study?
Approximately 24 people will be interviewed for this study.

What will happen if I take part in this research study?
If you agree to take part in this study, the following will happen:

You will be interviewed by the researcher in an agreed upon location that could include your residence or a private room at the St James Infirmary or the City Clinic Annex. The researcher will ask you questions about your experience being a female-to-male transgender person.

The researcher will make a recording of your conversation. After the interview, the researcher will type into a computer a transcription of what was recorded and will remove any names or identifying information from the typed document. The recording will be destroyed at the end of the study unless you agree to be part of a larger follow-up study, in which case it will be destroyed at the end of that study.

The researcher will interview you at least once. After reviewing his notes, he may contact you by phone or in person to ask you if he could talk with you a second time. It is up to you if you would like to have a second interview. The researcher will not do more than 2 interviews. Each interview will take approximately 60 minutes.

How long will I be in the study?
Participation in the study will take 1 to 2 hours over a period of several weeks.

Can I stop being in the study?
Yes. You can decide to stop at any time. Just tell the researcher right away if you wish to stop being in the study.

Also, the researcher may stop you from taking part in this study at any time if he believes that it is in your best interest, if you do not follow the study rules, or if the study is stopped.

What risks can I expect from the study?
You may feel uncomfortable discussing details of sexuality, but you are free to decline to answer any questions you do not wish to answer.

Are there any benefits to taking part in this study?
There will be no direct benefit to you from participating in this study. However, the information that you provide may help health professionals better understand and learn more about female-to-male transgender persons and enhance their health care.

What other choices do I have if I do not take part in the study?
You are free to choose not to participate in the study. If you decide not to take part in this study, there will be no penalty to you. You will not lose any of your regular benefits, and you can still get care from your regular provider.

Will my medical information be kept private?

We will do our best to make sure that the personal information gathered for this study is kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

If a health situation is uncovered by the researcher that poses an immediate threat to you, the researcher, as a mandated reporter, will be obligated to report this to the proper authorities. A potentially reportable situation includes risk for suicide. You may be at risk of intervention by state and local authorities if a reportable situation is detected.

Participation in research may involve a loss of privacy, but information about you will be handled as confidentially as possible.

What are the costs of taking part in this study?

You will not be charged for any of the study procedures.

Will I be paid for taking part in this study?

No cash is provided but all participants will receive a $20 gift card either handed to them at the end of the interview or mailed to their home if they prefer. An additional gift card of $10 will be given to any participants who have a follow-up interview.

What are my rights if I take part in this study?

Taking part in this study is your choice. You may choose either to take part or not to take part in the study. If you decide to take part in this study, you may leave the study at any time. No matter what decision you make, there will be no penalty to you in any way.

Who can answer my questions about the study?

You may speak with the researchers if you have any questions or concerns about this study. You may contact the Co-PI, Stefan Rowniak at 415 863-6615. You may also talk to the PI, Dr. William Holzemer by calling him at 415 502-8081.

If you have any questions, comments, or concerns about taking part in this study, first talk to the researcher (above). If for any reason you do not wish to do this, or you still have concerns after doing so, you may contact the office of the **Committee on Human Research**, UCSF's Institutional Review Board (a group of people who review the research to protect you rights). The CHR is independent of the research team and is available to answer any questions about your rights and welfare as a study participant.

You can reach the CHR office at **415 476-1814**, 8 am to 5 pm, Monday through Friday. Or you may write to: Committee on Human Research, Box 0962, University of California, San Francisco (UCSF), San Francisco, CA 94143

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Consent

You have been given a copy of this consent form for your records.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You have the right to decline to be in this study, or to withdraw from it at any point without penalty or loss of benefits to which you are otherwise entitled.

If you wish to participate in this study, you should sign below

_____

Subject Signature Date of Signature

_____

Signature of Person obtaining consent Date of Signature

Publishing Agreement

It is the policy of the University to encourage the distribution of all theses, dissertations, and manuscripts. Copies of all UCSF theses, dissertations, and manuscripts will be routed to the library via the Graduate Division. The library will make all theses, dissertations, and manuscripts accessible to the public and will preserve these to the best of their abilities, in perpetuity.

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Stuy R Rowan 8-2-10

Author Signature Date