Breaking Binary Boundaries: A Phenomenological Exploration of Gender Nonconformity

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Abstract
This phenomenological study examines the subjective experiences of self-identified transgender and gender nonconforming individuals. 23 participants were interviewed in an open-ended format about their gendered experiences. The interview questions covered information about the participants’ personal conceptualization of gender, the process of transforming their gender expression, the process of coming out, sources of stress and support, experiences of prejudice or discrimination, interactions with the medical and mental health fields respectively, and reactions concerning Gender Identity Disorder (GID) as a psychiatric diagnosis. The interviews were transcribed and analyzed using interpretative phenomenological analysis (IPA). The following superordinate themes were identified through IPA: (a) a period of questioning, (b) the importance of support, (c) the binary myth, (d) social concerns, (e) trans visibility, (f) reactions to the LGBT connection, (g) healthcare limitations, (g) reactions to GID, and (h) post-transition considerations.

Overwhelmingly, participants rejected the notion that alternative gender identities are synonymous with mental illness. The most commonly expressed belief by the participants was that informed and consenting adults, regardless of their gender identity, should have the final word about their bodies and their medical care. The results supported previous research related to gender as a social construct, rather than a biological determinant. The results also substantiated previous claims that transgender individuals frequently adhere to traditional gender presentations given the limited range of socially sanctioned gender identities. Directions for future research include a continued exploration of the detriment or benefit of retaining GID as a psychiatric diagnosis. It was also recommended that research aim to diversify transgender literature.
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BREAKING BINARY BOUNDARIES: A PHENOMENOLOGICAL EXPLORATION OF
GENDER NONCONFORMITY

A DISSERTATION
SUBMITTED TO THE FACULTY
OF
SCHOOL OF PROFESSIONAL PSYCHOLOGY
PACIFIC UNIVERSITY
HILLSBORO, OREGON

BY
STACI A. WADE-HERNANDEZ

IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
OF
DOCTOR OF PSYCHOLOGY
MARCH 2012
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Overwhelmingly, participants rejected the notion that alternative gender identities are synonymous with mental illness. The most commonly expressed belief by the participants was that informed and consenting adults, regardless of their gender identity, should have the final word about their bodies and their medical care. The results supported previous research related to gender as a social construct, rather than a biological determinant. The results also substantiated previous claims that transgender individuals frequently adhere to traditional gender presentations given the limited range of socially sanctioned gender identities. Directions for future research include a continued exploration of the detriment or benefit of retaining GID as a psychiatric diagnosis. It was also recommended that research aim to diversify transgender literature.

Keywords: transgender, gender nonconforming, Gender Identity Disorder, gender binary
Acknowledgements

I am deeply indebted to my parents, James and Cynthia Wade, for their unwavering generosity, inspiration, motivation, and encouragement. Thank you to my husband, Nathaniel Hernandez, for his steadfast patience, love, and understanding. Thank you to my chair, Dr. Johan Rosqvist, and my reader, Dr. Cathy Moonshine, for their willingness to support this project. Lastly, a special thanks to the courageous and candid individuals who shared their stories with me and made this possible. This is for you.
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INTRODUCTION

Ideas, expectations, and beliefs about gender are built into the structure of our society. Gender identity has generally been presumed to follow suit with external genitalia, the physical marker of one’s sex. Individuals who adopt a gender identity or presentation that does not match their sex challenge the social order by not acting according to standards that have been socially approved (Gagne, Tewksbury, & McGaughey, 1997). The gender binary that predominates Western culture has made it challenging for individuals who do not fit cleanly in one category or the other to find self-acceptance or to be acknowledged and understood socially (Gagne, Tewksbury, & McGaughey, 1997). The ubiquitous and commonplace nature of gender allows it to generally go unnoticed until socially accepted gender norms are defied.

Gender expression is limited by the existing gender structure, which only offers two acceptable options from the flawed supposition that gender should correspond to sex. Those who do not adhere to the gender norms equivalent to their physical sex are frequently expected to conform to a more traditional presentation. The gender binary insists that gender nonconforming individuals adopt either a male or female identity and socially present themselves as members of that sex category. Individuals who do not pass as male or female are subject to an increased risk of emotional and physical abuse (Gagne, Tewksbury, & McGaughey, 1997).

Many may chose a cross-gender expression in an effort to escape stigma or to fulfill a desire to be socially legitimized (Gagne, Tewksbury, & McGaughey, 1997). Those who do not adopt a male or a female presentation pose a major threat to the existing binary system. Challenging the binary involves coping with the hostility and discomfort of those who insist on clear categorization. Given the difficult task of finding support, safety, and a voice in a world structured around the recognition of only two genders, it is explicable that many transgender
individuals assume an identity that fits within the binary. A new system of gender may be a preferable alternative to pathologizing and chastising those who do not fit the preexisting model.
Literature Review

Terminology

A small portion of existing terminology related to the transgender experience includes gender, gender identity, genderqueer, transgender, transsexual, cross-dresser, and sex reassignment surgery (SRS). Gender is a social construct that is currently divided into male and female categories that are assumed to correspond to physical sex characteristics. Gender identity refers to an individual’s personal ideas and beliefs about their gender, regardless of their natal sex (Lev, 2004). Gagne, Tewksbury, & McGaughey (1997) maintained that gender and gender identity are learned and realized through social interactions. They stated that gender is culturally actualized and is imposed by families, politics, law, and religion.

Genderqueer is an umbrella term that describes the broad spectrum of possible gender identities outside of the gender binary. Virginia Prince created the term transgender in the 1970s to describe people who permanently lived as a gender that did not match their biological sex (Drescher, 2009). The term transgender has evolved and is now an umbrella term that describes individuals who do not adhere to established gender norms for their biological sex in either identity or presentation. Transsexuals and cross-dressers can both be considered transgender. Transgender identity does not determine sexual orientation (Korell & Lorah, 2007).

Cross-dresser refers to an individual who dresses in a manner that is characteristic of the opposite sex from that individual’s biological sex. According to Lev (2004), the term transsexual describes people who do not believe their physical bodies signify their true sex and therefore make a variety of choices, from changes in clothing to surgery, to align their sex and gender. Sex reassignment surgery (SRS) is a procedure that alters an individual’s primary or secondary sex characteristics. SRS can involve genital reconstruction, breast implants, electrolysis, paring
down of the Adam’s apple, or mastectomy (Korrell & Lorah, 2007). Transgender individuals obtain eligibility for SRS through a variety of steps including psychological evaluation and hormone therapy. Clinicians assume a dual role of therapist and evaluator and must safeguard against the likelihood that this will compromise the process and effectiveness of therapy (Bolin, 1988).

Affirmative descriptors of the transgender experience are difficult to come by. Therefore, finding the appropriate language to discuss transgender issues can be challenging. Some members of the transgender community have addressed this dilemma by creating inclusive and creative pronouns to describe themselves. Sie, ze, and hir are examples of pronouns that are beginning to defy the reigning gender dichotomy.

**Transgenderism**

Similar to historical perceptions of homosexuality, transgenderism has largely been perceived as depraved or unnatural (British Association for Counselling and Psychotherapy [BACP], 2007). Moral and religious disapproval provides the context for the shame and fear that has surrounded homosexual identity since the Middle Ages (BACP, 2007). Homosexuality was formally endorsed as an illness to be cured. Lesbian, gay, and bisexual (LGB) individuals who sought out psychotherapy to become heterosexual in the time between the 1950s and the 1980s unfortunately faced an outcome of treatment that generally involved a worsening of self-esteem and overall mental health (BACP, 2007). A gradual shift in attitudes led the American Psychiatric Association to remove homosexuality as a mental disorder from the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1973. Homosexuality was not removed from the International Classification of Diseases (ICD), however, until 1992.
Transgenderism continues to be pathologized in the medical and mental health fields. In 1953, Christine Jorgenson underwent partial SRS in Denmark as an attempt to “cure” her homosexuality. When Jorgenson returned to the United States, her surgery went public as a sex change. The psychiatric community criticized the treatment and claimed that psychotherapy should have been used to treat the “perversion” (Cohen-Kettenis & Pfafflin, 2010). This case initiated the battle between the clinical disciplines to dominate the field and determine the treatment of transgenderism.

The World Professional Association for Transgender Health, formerly named the Harry Benjamin International Gender Dysphoria Association, was the first international professional organization to establish and distribute Standards of Care (SOC) for the treatment of people experiencing gender dysphoria. The SOC addressed issues of assessment and eligibility for SRS. The inclusion of transsexualism as a diagnosis in the DSM-III was fueled by the belief of the mental health community that psychiatrists should be involved in the process of determining a patient’s eligibility for SRS. Historically, the diagnosis has been directly tied to SRS. This has generated concerns and criticisms about a mental health diagnosis being treated primarily through body modification surgeries.

**Gender Identity Disorder**

The challenges that transgender people confront in regards to self-understanding and acceptance are lessening over time. However, gender minorities continue to encounter many of the same obstacles that sexual minorities once faced. One such obstacle is highlighted in the debate surrounding the inclusion or removal of a psychiatric diagnosis related to gender dysphoria in the DSM. "Whereas gay men and lesbian women are diagnosed for how they suffer [e.g., depression], transsexuals are diagnosed for who they are" (Wyndzen, 2004, p. 3).
Gender Identity Disorder (GID; see Table 1) is the only diagnosis related to gender problems in the DSM-IV-TR (APA, 2000). A distinction remains between childhood, adolescence, and adulthood GID. The DSM has consistently approached gender from the stance that a psychiatric condition is signaled when sex and gender do not correspond. The axis and label for gender identity problems have changed throughout versions of the DSM, but the distress regarding one’s assigned gender has remained a constant. One of the many concerns about the inclusion GID in the DSM is whether the diagnosis can be made reliably. It is a legitimate and unfortunate concern, given that clinical research has not been conducted to address the reliability or validity of the diagnosis (Cohen-Kettenis & Pfafflin, 2010).

According to Cohen-Kettenis and Pfafflin (2010) the current criteria for GID in the DSM-IV-TR (APA, 2000) presents a number of problems. The authors addressed these problems apart from the general disagreement as to whether the diagnosis should exist at all. They contended that there is confusion regarding the similarities and differences between transsexualism, a diagnosis that appeared in the DSM-III (APA, 1980), and GID. The diagnosis of GID is frequently used in the same way that the transsexualism diagnosis was and altering one’s physical self continues to be presented as the only alternative to a psychiatric diagnosis. They also stated that the criterion for GID does not account for the entire continuum of gender variance and places individuals at risk for invasive and unnecessary exams to rule out intersex conditions. Cohen-Kettenis and Pfafflin (2010) noted that a particular weakness of the current criteria is that all individuals who experience discomfort with their sex characteristics and present an alternative gender identity, despite the degree or type, will likely fulfill the current GID criteria.
Table 1

**DSM-IV-TR Criteria for Gender Identity Disorder**

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Code based on current age: □

302.6 Gender Identity Disorder in Children

302.85 Gender Identity Disorder in Adolescents or Adults

Specify if (for sexually mature individuals):

Sexually Attracted to Males □

Sexually Attracted to Females □

Sexually Attracted to Both □

Sexually Attracted to Neither
The DSM-IV-TR conceptualizes gender as an either/or category, erroneously assuming that gender is a dichotomy made up of male and female, which is demonstrated through the use of terms such as cross-gender identification. A dimensional diagnosis would more accurately and appropriately reflect the heterogeneity of the population it is intended to serve. Gender nonconforming individuals may only experience the distress component of the GID diagnosis until they are able to reconcile their gender identity and live accordingly. SRS may or may not be a part of the reconciliation process. Clinicians are now met with varied treatment requests outside the realm of SRS.

Ault and Brzuzy (2009) argued that body modification surgery should not be regarded as a necessary treatment for a psychiatric diagnosis. Conversely, a GID diagnosis should not be required for individuals to choose SRS. Non-transgender individuals are not deemed mentally ill if they elect to modify their bodies and the same should be true for transgender people. Ault and Brzuzy (2009) argued that GID is a conflict between societal norms and individual identity, which is not a justifiable foundation for a mental health diagnosis. They stated that diagnosing alternative expressions of gender promotes discrimination and stifles self-exploration.

The APA is in the process of revising the DSM-IV-TR and the publication of the DSM-V is expected in 2012. The revision has prompted concerned responses from the LGBT community, particularly in regards to the GID diagnosis (Drescher, 2009). One side of the debate argues that the transgender community is harmed by a diagnosis that stigmatizes alternative gender expressions. The argument is similar to the battle against homosexuality as mental disorder in the 1970s. It advocates for a normative view of the transgender experience. The other side of the debate voices concern that removing GID will result in the inability of transgender individuals to receive medical services, including SRS. The APA has not provided a formal
opinion regarding treatment of GID, which has led many insurance companies to deem the SRS elective. Therefore, the presence of the diagnosis may not provide access to the services thought to justify the diagnosis (Drescher, 2009).

Efforts exist to find a middle ground between justifying the need for treatment while avoiding stigma. Drescher argued (2009) that retaining, but modifying the diagnosis would best uphold the dictum “first do no harm”. He contended that the GID criterion should focus more specifically on individuals who are distressed about the incongruence between their gender identity and physical sex, so as to reduce the stigma and exclude individuals who do not experience psychological and physical dissonance. Drescher (2009) also posited that the stigma that may coincide with retaining a modified diagnosis is less harmful than the refusal of surgical care that would likely result from removing the diagnosis altogether. He offered five recommendations to the DSM-V Workgroup on Sexual and Gender Identity Disorders:

1. Remove stigmatizing language regarding gender variance.
2. Separate gender diagnoses from sexual dysfunctions and paraphilias.
3. Clarify confusion between GID categories in adults and children.
4. Narrow the criteria so the diagnosis only applies to those who are anatomically dysmorphic.
5. As attitudes evolve, reevaluate the inclusion of gender diagnoses.

Shelley (2009) stated that reforming the GID diagnosis is an important step toward the acceptance and understanding of transgender individuals. He argued that transgender people must have access to livable bodies and need space where they feel safe to exist, as they desire, without threats of violence. Peel and Thompson (2009) called for a rejection of pathology in favor of practices and policies that are strengths-based and positively focused. It appears that
things are slowly headed in that direction. In May of 2009, France became the first country to remove transsexualism as a psychiatric disorder.

**The Transgender Experience**

Gender is inescapable in every day life. Gender identity is interpreted through the language we use, the clothes we wear, and the careers we chose. Questions about one’s assigned gender and natal sex can arise as early as 2 years old (Cohen-Kettenis & Pfafflin, 2003). Feelings associated with the transgender experience are generally the strongest during puberty upon the arrival of secondary sex characteristics. Transgender individuals may experience a heightened sense of loss, confusion, and isolation during this time. Substance abuse, suicidality, depression, and self-harm are common risks for transgender youth due to ostracism and stigma (Korell & Lorah, 2007).

Transgenderism has come up against prejudice and discrimination in both the therapeutic community and society at large. Negative responses from friends, family, coworkers, employers, and society can cause gender nonconforming individuals to suffer and to question their sense of self. Israel and Tarver (1997) reported that 50% to 88% of transgender youth have contemplated or attempted suicide. In addition, they stated that negative outcomes likely result when clients are misdiagnosed or forced to make treatment decisions that are based on the agenda of mental health professionals. Transgender identity is not synonymous with pathology or a need for mental health services (Korell & Lorah, 2007). Transgender clients may present to therapy with gender concerns that are a natural part of self-exploration.

Laws that regulate or control the lives of transgender individuals are numerous and varied. It is imperative that affirmative clinicians are aware of such laws. Sexual harassment and discrimination are a risk for transgender individuals and they may not be protected against such
offenses (Korell & Lorah, 2007). Transgender people may be victimized in a variety of ways, from subtle harassment to verbal, physical, and sexual assault (Korell & Lorah, 2007). Violence is a primary threat to the transgender community. Lombardi (2001) reported that discrimination or violence was a reality for more than half of all transgender individuals. In 2008, the National Coalition of Anti-Violence Programs (NCAVP) reported that LGBT murders were at the highest level since 1999, rising 28% from 2007 to 2008. The NCAVP (2008) expressed a belief based on data they collected that violence permeates the lives of transgender people and that it is drastically underreported.

Employment concerns are pervasive in the lives of transgender people as well. Transgender individuals may fear being discovered or having their transgender identity revealed in a problematic or untimely way in the work setting. Additionally, they may be fearful of backlash or discrimination from employers or coworkers if they chose to disclose their gender identity. Those who chose to come out may do so in an effort to reduce isolation, fear, and dissonance (Israel & Tarver, 1997). It is important to address whatever concerns clients bring to therapy and not to make assumptions about the shape those concerns will take. Transgender individuals may enter into therapy due to concerns or confusion surrounding their gender. However, this does not indicate pathology and may or may not be the focus of therapy and treatment goals. According to Korell and Lorah (2007) most transgender individuals enter into therapy not because they are transgender, but because they are experiencing the same issues commonly encountered by the general population.

The transgender community has increased its political presence by uniting with the LGB community. Trans advocacy involves the promotion of access to health care, civil rights, and tolerance of gender nonconformity. Though the inclusion of transgender in the LGBT acronym
has improved the visibility, validation, and support of the gender nonconforming community, it has also created the illusion that the therapeutic needs of the transgender community match those of the LGB community. In addition, the disparity in social acceptance between the LGB community and the transgender community may lead to feelings of helplessness and division.

Gender identity can be explored through changes in dress and presentation, as well as through temporary or permanent alterations of primary and secondary sex characteristics. Transgender individuals may find shared community through such changes. Change occurs on both an individual and social level over time. Gagne, Tewksbury, & McGaughey (1997) stated that an alternative gender identity can only be attained through social recognition and reinforcement, which is why transgender individuals have a strong desire for social expression. Transgender people are commonly able to reject internalized messages that they are deviant or wrong when they find others who have rejected guilt and shame (Gagne, Tewksbury, & McGaughey, 1997). Nevertheless, exploring and resolving an identity that falls outside what is culturally understood can be challenging for some and impossible for others.

An alternative gender identity generally involves acknowledging and accepting the identity, regulating social presentations, and, for some, adjusting to anatomy transformations (Gagne, Tewksbury, & McGaughey, 1997). Gender transformations also typically involve an assessment of sexual identity. Changes in gender identity inevitably involve sexual implications. Internalizing the identity of the sex that corresponds to one’s presented gender may lead to a new way of defining or conceptualizing one’s sexual orientation (Gagne, Tewksbury, & McGaughey, 1997). Unfortunately, this frequently occurs in a system that does not attend to or acknowledge sexual matters for those who challenge the gender binary. Transgender individuals often face the unique obstacle of often being forced to come out due to changes in gender presentation or
physical appearance, whereas LGB individuals may be able to selectively choose when they feel comfortable and safe to come out.

**Affirmative Treatment**

Korell and Lorah (2007) outlined seven of their beliefs specific to working with transgender individuals:

1. Most therapists will encounter at least one transgender client during their careers.
2. The families of transgender individuals will be therapeutic clients more often than the transgender individuals themselves.
3. The majority of clinicians are limited in their knowledge and understanding of transgender issues, as well as their competence working with transgender clients.
4. Gender variance is not synonymous with pathology,
5. Transgender identity does not dictate sexual orientation.
6. Transgender clients and the general population come to therapy for the same reasons.
7. SRS is not always the treatment goal of transgender clients seeking psychological services.

In a systematic review of studies of counseling and psychotherapy for LGBT individuals, the BACP (2007) found few papers on psychotherapy for transgender people that were not focused on the preparation for, or outcome of, SRS. There were no studies solely focused on transgender issues that met criteria for inclusion in their review. The BACP (2007) summarized eight findings from the broader LGBT literature that was reviewed:

1. LBGT and non-LGBT individuals sought therapy for similar reasons.
2. LGBT people sought therapy more often that non-LGBT people.
3. LGBT clients defined affirmative therapy as treatment in which prejudice was avoided, bias was recognized, and LGBT identity was regarded positively.

4. Dissatisfaction in therapy was related to ignorance regarding LGBT issues or therapist hostility.

5. Consistent use of standard assessment measures was rare and therapists were generally rated in terms of perceived helpfulness.

6. Most quantitative studies used convenience samples, which limited the generalizability of the existing results.

7. The desire for a LGBT therapist was present, but not unanimous.

8. Attempts on the part of the therapist to pathologize or change sexual orientation usually lowered perceived helpfulness and client satisfaction with therapy.

The BACP (2007) also reported that the reviewed studies indicated that therapy helped LGBT individuals challenge homophobia, normalize their daily experiences, and deal with issues not related to their gender or sexuality. Based on their findings, they offered a variety of recommendations for psychologists, such as the pursuit of training that addresses the needs of the LGBT community, recognition and avoidance of a heteronormative bias, refraining from using clients as a means of educating themselves about LGBT culture, and providing care for transgender individuals that does not focus exclusively on gender change. Though affirmative therapies for LGBT individuals have been in development for the past three decades, there remains a gap in the knowledge and understanding of the needs of this population, their vulnerabilities and strengths, how therapy is provided to this population, and whether it’s effective (BACP, 2007).
Purpose of the Current Study

The attention on transgender people in scientific literature has primarily stemmed from a desire to understand their departure from the binary system. There has been minimal emphasis to date on the potential for an entirely new structure and conceptualization of gender. In addition, a large gap in transgender research exists regarding alternative conceptualizations of gender, diversity considerations, barriers to treatment, positive terminology, and affirmative therapy, particularly from the perspective of the population served. This study will address treatment considerations for transgender people by interviewing individuals who identify as gender nonconforming. Interviews will cover information that will fill in gaps related to the unique needs of this population and how to appropriately and effectively serve them. I hypothesize that the participants will report that the GID diagnosis serves as more of a hindrance than an aid. I also hypothesize that the majority of participants will report that medical and mental health communities are limited in their ability to provide competent and affirmative services due to their adherence to the culturally dominant binary system of gender.
Method

Rationale for Qualitative Methodology

I chose a qualitative approach for this study in an effort to give a voice to a frequently silenced or misunderstood population. Diagnosis and treatment assumptions made regarding transgender individuals may directly harm them in the therapeutic process or prevent them from accessing services. In regard to such issues, qualitative methodology allows for a more thorough understanding than a quantitative approach.

This study addressed treatment considerations for gender nonconforming people by interviewing them directly. Given the absence of literature on the topic, the interviews attended to the distinct needs of the transgender community. The qualitative research design I chose for this study was interpretative phenomenological analysis (IPA). The purpose of IPA is to explore how people understand or assign meaning to their individual and collective experiences (Smith & Osborn, 2008). A phenomenological approach allowed for an in-depth examination of the participants’ subjective experiences of gender. From an IPA approach, the researcher is viewed as an active contributor in the interview process, working to understand the participants’ perspectives (Smith & Osborn, 2008).

Participants

I solicited participation for the study by sending an e-mail (see Appendix A) and an accompanying flyer (see Appendix B) to support groups, community agencies, and mental health providers that serve gender nonconforming individuals in the greater Portland area. A brief description of the study was included in the initial e-mail. Volunteers were asked to contact me by phone or e-mail if they were interested in scheduling an interview. In order to be included in the study, participants needed to be 18 years or older, identify as transgender or gender
nonconforming, and be able to provide informed consent. 23 individuals who met the eligibility criteria agreed to participate and contacted me to schedule an interview. In the final sample (see Table 2), five individuals described their gender as male (female-to-male [FTM]), 14 individuals described their gender as female (male-to-female [MTF]), two individuals described their gender as queer, one individual described their gender as “3rd gender,” and one individual described their gender as “it depends.” In regard to assigned birth sex, fourteen participants reported “male,” eight participants reported “female,” and one participant reported “intersex.” The mean age was 43.61 years (SD=15.39), with a range of 18 years to 68 years. The majority of the participants identified as Caucasian, two as Hispanic, one as American Indian, and one as Slavic. Almost all of the participants had at least some college education, one was a high school graduate, and one had some high school education. The sample included nine married or partnered individuals, nine single individuals, and five divorced individuals. Due to the absence of widely accepted gender-neutral pronouns, and in an effort to protect participant confidentiality, all participants are hereafter referenced by the personal pronoun ‘they.’
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Data Collection

I began recruiting participants for the study once I received approval from Pacific University’s Institutional Review Board. As volunteers contacted me to participate in the study, I answered questions and scheduled interviews. Over a period of four months, I completed 23 semi-structured, in-depth, audio-recorded interviews with individuals who self-identified as transgender or as living outside of the dominant gender structure. All interviews were conducted in person or over the phone by the primary author in a confidential setting.

Each participant was given an informed consent form (see Appendix C) to read before the interview. I reviewed the information on the form and answered any clarifying questions before the participants signed the form. Participants were asked to electronically sign the informed consent form and return it by e-mail, prior to a phone interview. All participants were notified that the interviews would be audio recorded. I agreed to share the results of this study with participants who expressed interest.

Participants were then asked to fill out a demographic questionnaire (see Appendix D) that covered information such as age, education, occupation, gender, natal sex, and partnership status. The interviews ranged from 20 minutes to two hours, with most interviews lasting approximately one hour. The participants were guided through a series of questions related to their gender identity, including their personal conceptualization of gender, the process of transforming their gender expression, the process of coming out, sources of stress and support, experiences of prejudice or discrimination, interactions with the medical and mental health fields respectively, and reactions concerning GID as a psychiatric diagnosis. At the end of each interview, participants were given the opportunity to ask questions or offer additional comments. I then thanked the participants for their involvement in the study. Interviews were transcribed in full by
the primary researcher. Names and other identifying pieces of information (e.g., place of employment) were removed from the transcripts.

**Interview Questions**

**Gender conceptualization.**

How would you describe your gender and gender identity? How did you arrive at that definition? Do you have a preferred pronoun? How do you respond to labels? Is it important to have labels? How do you (or do you?) inform others about your preferred use of descriptive language regarding your gender identity? What are the pros and cons of being included in the LGBT acronym?

**Gender transformation.**

Describe the process of transforming your gender identity and gender expression. What steps did you take? What support did you receive in the process? What aspects of the process, if any, were particularly difficult or stressful? What are the benefits of the transition? What are the inherent challenges of coming out to the various people in your life (i.e., friends, parents, siblings, co-workers, etc.)? How do you determine who is safe to come out to?

**Risk factors and vulnerabilities.**

Have you ever experienced prejudice or discrimination as a reaction to your expression of gender? Do you know someone who has? What effect, if any, has this had on your mental and emotional well-being? Have you ever been a victim of violence due to your gender identity? Do you take steps to protect yourself?
Accessing services and barriers to treatment.
Describe your experiences accessing medical and mental health services. What barriers have you encountered? What have you found helpful or unhelpful? How do you respond to forms, policies, and procedures that are not inclusive of alternative gender identities?

Diagnosis, treatment, and reactions to GID.
Have you ever sought mental health services? If so, what were/are your primary mental health concerns? How would you describe affirmative treatment? What has worked in the past and what hasn’t worked? Have you ever had a Gender Identity Disorder diagnosis?
What are your reactions to a psychiatric diagnosis related to gender dysphoria? Have you pursued SRS? Do you think that SRS is an appropriate treatment for gender dysphoria?
What are some potential alternative treatment goals? Do you feel that the existence of the GID diagnosis perpetuates stigma or that it is necessary for access to medical services?

Data Analysis
According to Smith and Osborn (2008), IPA research questions are constructed in an effort to openly explore an issue. Sample sizes are generally fairly small given the detailed analysis of each individual transcript and interviews are commonly audiotaped and transcribed in full. For the purposes of this study, I followed the recommended steps outlined by Smith and Osborn (2008) for IPA research. Semi-structured interviews were conducted to allow for flexibility and follow-up on interesting responses.

The first stage of IPA involved looking for themes by familiarizing myself with every case. Each transcript was read in detail several times. I used the left-hand margins to note relevant or thought-provoking responses (Smith & Osborn, 2008). Annotations were unrestricted and included comments regarding associations, similarities, contradictions, summaries, and
interpretations. Upon reading each transcript a second time, I noted developing themes in the right-hand margins. I transformed my initial comments into succinct, slightly more conceptual phrases intended to portray the essence of the participants’ responses. Smith and Osborn (2008) asserted that the connection to the participants’ original statements should be clear. The notes from each transcript were reviewed in entirety and transformed into themes.

The next stage of IPA involved chronologically listing the themes that surfaced and searching for connections between them. I then created another list, placing the themes in theoretical order based on the connections I recognized in the previous step (Smith & Osborn, 2008). Some themes clustered together, while others remained distinct. Smith and Osborn (2008) stressed the importance of checking the researcher’s understanding and interpretations against the participant’s actual responses. Therefore, I reviewed the original transcripts to ensure that the clustered themes reflected the words of participants. Similarly, I created a list of participant phrases that reinforced the associated themes.

The subsequent stage of my analysis involved naming each cluster as a means of representing superordinate themes. Superordinate themes were ordered logically, with the original corresponding subthemes listed below. The subthemes included a page number and phrase identifier from the original transcript (Smith & Osborn, 2008). Themes that were unsupported or unfit were removed throughout the process of analysis. As I worked my way through each interview, I diligently noted themes repeating from previous transcripts as well as new or contradictory ideas. According to Smith and Osborn (2008), the researcher should aim to recognize both the differences and similarities between participants’ accounts.

I began the analysis of each transcript as if it was the first, rather than using the emergent themes and structure of previous transcripts as a guide. I looked for differences and similarities
between cases once each case was analyzed separately. After each transcript was analyzed, I constructed a final table of superordinate themes (Smith & Osborn, 2008). Themes were selected based on the richness and complexity of content, rather than frequency of appearance. The final themes highlighted both the theoretical similarities between participants and the distinctive ways in which those similarities were expressed (Smith & Osborn, 2008). A narrative explanation of the final themes from this study can be found in the results section.

Interrater Agreement

In an effort to validate the findings of this study, I secured the aid of a doctoral student from Pacific University who is familiar and experienced with qualitative research, specifically IPA. I requested that he analyze three of the transcripts at random. Upon completion of his analysis we compared results. We looked for common and contradicting themes, as well as any potential biases that may have emerged during my analyses. The comparison revealed that each of the themes he identified appeared in my list of superordinate themes and subthemes, using comparable terms and phrases. No adjustments to my final analysis were deemed necessary.
Results

Data Analysis

As previously explained, the process of isolating themes began by familiarizing myself with the transcribed interviews and identifying what I perceived to be significant responses. The extracted responses were then transformed into phrases intended to convey the general meaning. For example:

Like, if I go to PFLAG and stuff like that, when we have our round circle and we have to tell who we are, the person next to me will go, ‘I didn’t know you were a woman, a transsexual woman.’ That’s a compliment for me. That’s the way it is. I pass very well. I’m very lucky to have had the genes that went so well with the hormones.

I transformed this particular response into the phrase: *I feel fortunate to pass*. Once the phrases of meaning were noted in the margins of each interview, I created a comprehensive list that allowed me to begin searching for connections between all of the phrases. As connections surfaced, I created another list that placed the meaning phrases in theoretical order. I combined overlapping responses so that the remaining phrases were distinct. A list of participant quotes was compiled to support the existing meaning phrases. The subsequent stage of my analysis involved clustering related phrases as a means of identifying subthemes. For instance, the phrases *I feel fortunate to pass*, *It is important and beneficial to be stealth*, and *I want to blend* were compiled into the Passing Privilege subtheme. Closely related subthemes were combined into superordinate themes. In this case, the subthemes of Passing Privilege and Blending in the Binary were clustered under the superordinate theme of Trans Visibility. This process of analysis continued until all phrases were converted into separate and significant themes. What follows is a narrative explanation of the final themes from this study.

Superordinate Themes and Subthemes

Superordinate Theme 1: Period of questioning. Theme 1 addresses the initial period of
questioning related to ones assigned gender, which includes Denial, Confusion and Uncertainty, Incongruence, and Experimentation and Acceptance. Subthemes will be discussed individually and supported by illustrative quotes.

**Subtheme I: Denial.** The period of questioning for many participants involved resistance, denial, and self-deception. Participant 3 described the deleterious effect of such an approach:

I mean it was a constant deception thing and it was horrible and I hated it and it finally came to a point where it couldn’t get any worse basically. And um, I couldn’t hide it anymore. So I had to come out so to speak and be who I was.

Simply stated by Participant 2, “I led my entire adult life so deeply closeted regarding the gender variance stuff.” Participant 20 spoke about denying their gender identity as a means of survival:

What you do is you put the female behind the curtain who just occasionally gets to peek out and say, ‘Well, I’m still here.’ You do this basically in order to survive. Particularly during those times (referring to the 50s), being transgender or transsexual could get you very definitely killed.

Similarly, the stigma that continues to surround transgender identity led to a period of outright denial for Participant 4:

I said like my whole adult life, um, I would love it if my voice were different. I've never wanted my boobs. I always wanted those cut off. Um, and I've always wanted facial hair, I just always wanted sideburns. And, and, I said that my whole life and then the end of that statement was always, ‘But I'm not a tranny, I don't want to be a tranny.’ Because I had a lot of stigma attached to that.

**Subtheme II: Confusion and uncertainty.** Though most participants had some awareness of gender issues from an early age, that awareness was often accompanied by doubt, confusion or emotional upheaval during the period of questioning. Participant 1 crafted the following metaphor to share their experience of uncertainty:

I mean it was almost like when you first get a toothache, where at first you are thinking, ‘Oh, it's nothing.’ You just tell yourself that it's going to go away on its own, but then as time goes on, it’s still there and for a time you may think, ‘Oh, it's still going to go away
on its own,’ even though you kind of know that it won't. And then after a while um I came to realize that this was who I was.

Participant 1 went on to describe the challenge of questioning their assigned gender without role models or examples to refer to:

I guess part of what was hard is that um, I didn't have a point of comparison as far as (pause) I knew what the thoughts were in my head, but I didn't know what the thoughts in other peoples’ heads were. At the time I thought, ‘Well maybe it's just what other guys ponder about.’ But I did come to realize that um, I was transgender.

According to Participant 3, a portion of their fear and uncertainty stemmed from the role religion played in their life at the time. “I thought I was going to hell my whole life. That was a pretty heavy thing for a little kid to be carrying around.” Participant 12 voiced their questions and uncertainty:

You know, yeah, the transition is just this giant mindfuck. You know like, the upheaval emotionally that happens when you realize like, you thought you were one thing for all these years and it turns out you weren't. What does that mean for who you are and, you know, sort of the fear that I had and that I hear a lot trans people talk about going into transitioning is like, will I recognize myself at the end of this process? Will I still be able to do all the things that I did before and like all of the same things? Will I (pause) who will date me, how will I navigate that? You know, that kind of stuff. It was mostly difficult on an emotional level, more than like a logistical level. Although that was difficult too. But I was lucky to have a lot of support from my friends and community resources.

Subtheme III: Incongruence. Feeling mismatched with one’s assigned gender, or more broadly that something wasn’t quite right, was frequently endorsed as a trigger for a period of questioning. In reference to their sense of physical incongruity, Participant 1 stated, “I would look in the mirror and I would see someone looking back at me, but it doesn’t feel like it’s me. It’s like I’m looking at someone else.” The feeling that something was amiss was echoed by Participant 2, who remarked, “It was an abstract thought since I was a child. Before I had words, vocabulary, I knew that something was odd. Not right.” Similarly, Participant 3 said, “Growing up in a very small town and thinking things that other kids didn't think. You knew not to tell
anybody, but you also knew that something wasn't right.” Participant 18 noted, “I tried really hard to do the whole boy thing for a long time and it just didn’t fit.” Participant 17 shared their experience of coming to terms with their childhood uncertainty later in life:

Um, having an awakening at like 33 or 34 and being like, oh my god, it’s not that I’m like weird or bad or something is wrong. It’s actually that I am just a woman and it took me this long to figure it out.

Subtheme IV: Experimentation and Acceptance.

The period of questioning was resolved for most through various forms of experimentation, eventually followed by acceptance of one’s true gender identity. Participant 17 summarized their gender journey:

It's difficult to explain, but when I was younger having like wet dreams and having fantasies about being with men, it was always in the body of a female. I thought maybe that was normal for gay men, but learning that that wasn't normal or an average experience of a gay man, but that was an average experience of a trans woman, you know. And then feeling like, with prosthetic breasts and like tucking and other things, looking at myself in the mirror and seeing a woman's body and a woman's face and feeling like alive in that moment and not feeling disembodied finally is a huge advantage and a huge plus. And that sort of makes everything else fall away, no matter what people say or think or how they treat me.

Many participants shared the perspective that embracing their true gender was inevitable, despite adversity. For instance, Participant 2 reported, “It was do or die. That was it. I didn’t have a choice.” Relatedly, Participant 3 stated:

It was a difficult thing to do. But I had to do it. It's not a choice. You either do it or die. Have I regretted the decision? Not in the least. It was the best thing I could have done for myself.

Participant 5 gradually replaced thoughts of doubt and confusion with thoughts of certainty:

I think to myself, ‘No, this is who I am.’ Who in their right mind wants to change their gender? Who in the their right mind wants to? I was born like this. Why? I don’t know. I don’t really care. I wish I was born female, but I wasn’t.
With the realization of their gender identity, Participant 9 adamantly voiced the inevitability of their transition:

In that one single instant, it was life shattering. I simply had to transition then, now, at any cost whatsoever, everything be damned and burn in hell. It had to be done immediately. There wasn’t even the option of dying, because dying would imply dying under a personality that no longer mattered.

**Superordinate Theme 2: Importance of support.**

The process of transitioning out of assigned gender roles and presentations was eased for most by support from their community. The fact that relationships were lost in the process made the relationships that remained even stronger.

**Subtheme I: Reliance on community.**

Participant 3 acknowledged the vital role that their friends played throughout their transition:

If not for the support of a few very good, good friends, um, I don’t know what I would have done. I really don’t. Um, they saved me. They really did. If they would’ve rejected me too, ugh, I don’t know. I shudder to think about what would’ve happened.

Participant 19 also shared their feelings of good fortune; “I’ve been pretty lucky with everybody around me being very accepting. If not approving, at least accepting.”

Several participants discussed the experience of preparing for the worst and hoping for the best when disclosing their gender identity. They endorsed the importance of providing significant individuals (e.g., partners, parents, children, friends, and co-workers) with the time and space needed to adjust to the change. For some, such as Participant 2, the ability to remain patient paid off. They stated, “I’m very close with my mother and as I evolved, so did she to some extent.” Certain participants’ patience only extended so far, however. Participant 17 shared their experience of disclosure and the limits of their patience:
I just laid everything out in a really kind of frank way, because I'm tired of being sensitive to other people about my issues. So my family doesn't really play a supportive role in my life. I think at the most they are ambivalent, which for me is not really acceptable. I'm being patient, because I understand that it can be weird, you know. But I have no tolerance for other people being embarrassed by my experience, especially people who are related to me and have known me my whole life. If they are ignorant about it that's fine, but they can read a book or get in a support group. They don't have to stay in the dark if they don't want to.

Others shared Participant 17’s sentiment, demanding respect and tolerance from the people in their lives. Overall, a network of understanding and supportive individuals helped the participating individuals combat the feelings of loneliness and isolation that resulted from challenging the status quo.

**Subtheme II: Seeking mentors.**

Locating mentors was profoundly helpful for most who were approaching gender nonconformity with limited models and information. According to Participant 21, “Gender nonconformity is not (pause) it’s invisible a lot of the time and there isn’t a clear narrative of, of how to be this thing and that’s stressful.” Finding other individuals who had been through similar experiences eased feelings of stress and singularity. Participant 1 described their experience of meeting with a knowledgeable mentor prior to transitioning:

> We sat down for maybe an hour and a half or something like that, but just kind of talked about where things were with her and so on. It gave me some encouragement, I guess, that the process wasn't insurmountable. That it was something that someone could go through, I guess.

Participant 7 voiced comparable comfort and assurance from accessing mentors in the LGBT community:

> There are other people out there and not necessarily just transgender people. There are people with different gender identities that, you know, don’t fit the mainstream. And that’s positive, it’s good to know. It’s nice to know that you’re not the only one experiencing this, because you know, sometimes you feel when you’re dealing with the everyday mainstream population, you know, you feel like you’re a freak show. You know? So it’s nice to know you’re not the only one.
Subtheme III: Influential role of the Internet.

The introduction of the Internet drastically changed transgender and gender nonconforming individuals’ ability to access information relevant to their experience, as well as communicate with other individuals like them. Many participants endorsed feeling like the “only one” prior to the Internet. For instance, Participant 1 stated:

And um, and so this was sort of in the early 90s and my family had recently gotten Internet access and so I was able to find information online about how um, other people are like this and so on and it wasn't necessarily just me.

Participant 3 also endorsed positive changes that accompanied online access:

Being around like-minded people was a huge thing. You just, you always thought you were the only one. And before the Internet you were the only one. And so the Internet was a huge piece too. So the Internet, I would say, was a huge support. That didn’t come into my life until 1995. Um, up until that point I thought I was crazy. I thought I was the only one. And I didn’t know what I was going to do about it.

Participant 18 indicated that they used the Internet as a means of finding and connecting with mentors from the trans community:

I went online to a website that has a lot of different pages and stuff in support of trans women specifically. One of those was a successful transitions website and I scanned through that. It showed a woman who I thought looked very interesting who was an airplane pilot. I wrote her and she became my mentor and gave me the number of a couple other trans women who were in transition. And she had been through it; she went through transition in like the 80s as a commercial airline pilot. It was really awesome to have that support from her through the whole thing. Everything that happened, it was like I could write to her. I've never met her; to this day I've never met her, and yet she has had a profound effect on my life. So that was really cool.

Superordinate Theme 3: The binary myth.

Subtheme I: Complexity of gender.

All of the participants endorsed the complexity of gender at some level. Gender is abstract concept, easily taken for granted by those who identify with the gender they were assigned. For those who do not, such as the participants represented in this study, the gender
binary can be stifling. Participant 7 rejected the binary by stating, “You can love anybody you want because you can be anybody you want. You don’t have to be male or female.” Participant 10 spoke about adopting gender labels as a means of relating to others, acknowledging the limits of any one label in isolation:

I am presenting to pass as female now and other times because it is a convenient shorthand. It’s a label that I can put on myself to relate with the world in a particular way and be relatively safe while doing that.

Participant 18 acknowledged certain realities of the binary, while also identifying areas where gender extends beyond it:

I mean having a vagina is certainly different from having a penis. I mean just the physical differences, the fact that women menstruate. I mean that is a biological determinant, you know. That is a gender binary. And the fact that there is so much more that we all have in common with each other than that is different between men and women is not a gender binary. It's the opposite of that, whatever that is. The fact that, in general, men are bigger than women is the binary. And the fact that specifically there are women who are bigger than most men, that’s a continuum. So it's complex and ultimately does it matter? You know, only if we make it matter. Because it really doesn't matter if it’s just like, ‘Oh, you're human.’

**Subtheme II: Genderqueer.**

For many participants, Genderqueer was a more accurate or inclusive label than transgender or transsexual. The term Genderqueer encompasses the identity of all who fall outside of the heteronormative binary. Transitioning from one gender in the binary to the other was not desired or deemed necessary by all participants. For example, Participant 10 reported, “I realized that my path was not to live full-time as a woman to be who I am in the world.”

Participant 10 went on to share their feelings about the presence of the gender binary within the trans community:

If anything, one of the things that bugs me in the trans community is um, the the, I don’t know (pause) there is this implicit, ‘Are you on the transition track? Are you taking hormones?’ There’s all of this pressure and, you know, the gender binary shows up in weird, interesting ways.
Participant 13 stated, “I tend to think I’m a better man for being a woman.” They indicated that they are not clearly male or female, but are able to embrace the strengths of both sides of their gendered experience. Unfortunately, a gender blend can come with its disadvantages. Participant 4 described the negative reactions to their Genderqueer presentation:

My whole life I've confused people. And, and when you confuse people they tend to get angry. Um, just people don't know if I'm male or female, so sometimes that's upsetting to them.

**Subtheme III: Shifting toward a spectrum.**

The participants in this study likely stand to gain a great deal from a shift toward a gender spectrum, rather than a binary system. However, given their personal experiences, participants voiced varying degrees of hope for such a shift to occur. Participant 11 expressed their doubts:

I don't think we’re ever going to leave the binary system, because most of the population is very comfortable with it and it makes sense to them, you know. So there is always going to be a gender binary. But hopefully, and I think that there are some signs that this may be taking place in our culture, hopefully people are placing a little less importance on it. That's the main thing is that you don't let it get in your way of acting like a human. That's what I would like to see. There's been some progress in that direction. But it's never going to be perfect, because like I say, people want to recognize the difference between boys and girls.

According to Participant 5, the benefits of shifting toward a spectrum could potentially extend beyond the gender nonconforming community:

Some of the people who are really violently binary may actually open up and find out that they are not. Instead of having hard and fast rules as to what you do if you’re male and what you do if you’re female, people could do whatever they wanted to.

Participant 17 underscored the incomplete view of the binary system:

I don't think there's anything wrong with cisgendered people or heterosexual people, but it's certainly not the human experience. It's part of it, it might even right now at this time and place be the normal or the average for the majority, but it certainly doesn't speak for everybody.

**Superordinate Theme 4: Social concerns.**
Navigating gender was complicated for most participants by an array of social pitfalls, which included loss of relationships, prejudice, discrimination, violence, sensationalism, and language complexities.

**Subtheme I: Loss of relationships.**

Losing relationships was an unfortunate reality for most participants. Participant 2 described the sadness and loss that accompanied their transition:

I can’t see how a person could go through it without being depressed. Because the gender stuff is, you’re mourning a loss for something you never even had. And if you make the decision to go get what you need, you know you’re going to be mourning the loss of a whole lot of people who are not going to want you anymore. So you’re whole entire life is about loss. That’s depressing.

Participant 3 expressed both doubt and hope about the future of their relationships, while acknowledging their inability to control the reactions of others:

You expect to lose everything and everybody. But you don’t have a choice about it. You just hope that you have educated them in some way. That you told them that you cared about them in some way that they will not reject you for your truth. And after that, you can't do anything about it. They are going to do what they're going to do.

In a later comment, Participant 3 further stressed their point of view:

They were somewhere told that this was wrong. And they still believe it. And, um, how do you change their minds? You don't. You just keep being who you are and you keep caring about them. Because it doesn't do anybody any good to bad mouth them because they don't accept you. It's called the high road; I stay on it. I stay on it. But I can't worry about them. You know, it's their path. I thought I was a good person to be in their life, they obviously thought not. Okay, see you later, bye. I can't sit here and cry about it. You're not going to make me feel crappy because you don't accept who I am.

Similarly, Participant 2 expected limited understanding from some people:

I wrote a letter and detailed everything out and gave them the option to stay or go, without judgment. People can only do what they can do, or they can’t. That’s just the way it is.

Participant 20 highlighted the challenge of losing important relationships, but noted that the person experiencing the loss no longer exists in the same way:
Losing that forty-year friendship and losing my children was very hard for me, but it wasn’t me. It was another person that that happened to. The person I am now more than makes up for that.

Reinforcing the notion that gender identity is not a choice, Participant 8 emphasized the risk involved; “It’s putting at risk all your relationships, your employment, your safety; everything to do this.” Reconciling ones gender was such an inevitable necessity for most participants that facing the accompanying challenges was a given part of the experience. To not face the possibility of loss or rejection would mean continuing to live a lie, preventing them from developing truly authentic relationships.

Subtheme II: Prejudice, discrimination, violence, and sensationalism.

Experiencing prejudice, discrimination and/or violence was expected by almost all participants and experienced by most. Those who had not been directly victimized expressed feelings of luck or good fortune. Participant 10 commented on the expected risk of expressing a non-dominant gender:

I think thankfully the worst physical thing to ever happen to me was getting spit on. Um, I think I’ve been very fortunate. How crazy is it to say that I am fortunate because I haven’t been beat up, right? It’s crazy. But unfortunately I think that is the reality for a lot of trans people.

As a reaction to a lifetime of dealing with biases and bigotry, Participant 2 voiced their anger:

So as far as prejudice goes, does it still taint the way I think? Absolutely. But I do acknowledge it and I do work at keeping it in check. I tell you; at times it makes me violently angry. I won’t lie. As many times as I have been chased down and beat up and hurt and attacked and called out, it’s really hard not to want to lash out in the same manner.

In a similarly frustrated response, Participant 3 described their reaction to those who pass judgment:

I want them to know, this could happen to you. You think you’re special? That you get to think the way that you do, that you feel right in your own body? You think the way that you were born is because of you? You are dreaming. You are dreaming.
Several participants described public bathrooms as a particular source of stress. Participant 4 expressed bafflement about violence igniting due to one’s choice of restroom:

I hate bathrooms. Bathrooms are the worst part. Awful, awful. I mean that's one of the biggest reasons I don't like going out. I always choose the female bathroom. But, you know, it's like mission impossible. I use it as fast as possible. I've definitely had many different types of interactions, which mostly are just funny. Unisex bathrooms though, unisex bathrooms are the greatest thing in the world! Um, so exciting because no one even thinks about it. No stress there. People are so weird about it. You can't pee next to someone of the opposite sex? Why? I've heard too many stories about bad things happening to good people and it’s just like really?

Additionally, many participants conveyed frustration about the sensationalism and misrepresentation of transgender identities in the media. In reference to their son’s response to their transition, Participant 20 mentioned, “He identifies transgender as what you see on Jerry Springer or some other sensationalism, which is so much nonsense.” In a strikingly related statement, Participant 3 stated, “So many people, when they think of transsexuals, they think of Jerry Springer.” Echoing both statements, Participant 13 asserted, “I think that most of the portrayals of transgender people in the media, for the most part, tend to be sensationalized.”

Subtheme III: Managing language.

For many participants, disclosing their gender identity happened on a need to know basis. It was often endorsed as a contextual decision, based on the nature of varying relationships and the potential consequences of the disclosure. Managing the social perceptions of one’s gender generally involved changes in physical presentation as well as a shift in the language and labels one ascribed to. Adopting gender descriptors was particularly challenging for those who were questioning gender, identified as a middle or third gender, or were in the beginning to middle stages of their transition. Participant 1 endorsed a personal struggle with selecting applicable terminology:
I find that having to select labels for myself can be tough at times, just in the sense that um when most people offer those types of choices, they expect people to fall plainly within one bucket or another and that's not the case with me I guess.

Most participants acknowledged both pros and cons to gender labels. On the one hand, labels are a way of classifying the world and creating identity. They can be liberating and can demonstrate respect and understanding. On the other hand, labels can be damaging and problematic, particularly when they are used inaccurately or as a means of oppressing a group of people. Participant 18 noted that labels are often assigned too much power and do not communicate a true understanding of one’s identity:

I identify with some gender labels. But at the same time, that's not the whole story, that's not who I am in any kind of holistic sense. This is just one small aspect of my experience, of who I am.

Superordinate Theme 5: Trans Visibility.

Subtheme 1: Blending in the binary.

The shortage of transgender and gender nonconforming role models may in part be attributed to efforts by the trans community to be stealth in a binary system. Most participants endorsed efforts to pass in their daily lives and feelings of fortune if they were able to do so. Participant 13 reported, “I feel like I’m fortunate in that I feel that physically I pass well.” For some, this stemmed from a desire to fully embrace their gender identity. This was more likely to be the case with individuals who saw themselves clearly as a man or a woman, regardless of their assigned gender. For instance, Participant 8 stated, “I just want to blend in with the woodwork. I just want to be; you know (pause) I just want to disappear. Just lead my boring life, but as a female where I’m content.” Similarly, Participant 5 contended, “They always put out what the Bible says about a man should not dress like a woman and a woman should not dress like a man. That’s fine; I’m not a man.”
For others, blending into the binary was preferable in that it decreased the social risks previously mentioned, such as violence and discrimination. Also, it prevented individuals from constantly having to explain or defend themselves in a binary system of gender, particularly given the absence of well-known alternative gender labels. In reference to the benefits of transitioning, Participant 4 stated, “Um, to blend. To, to not be a freak. Um, at least in the eyes of those that I really don't want to be a freak to.” Participant 5 indicated that passing is a necessity in our society for transgender people. “So many of us are stealth, in the closet, that you would pass by us on the street and you wouldn’t even know. Um but for now, yeah, we have to be that way.” Participant 3 offered their point of view on the subject:

I don't broadcast it, so I am fairly safe in that regard. I'm sure that it would change if I started yelling what I was, but, um, other than a human being, which is what everyone tries to achieve.

Subtheme II: Passing privilege.

Given the societal pressures to blend into the binary, members of the trans community who are successfully stealth are often considered to have passing privilege. They are generally less likely to be questioned, taunted, or threatened because they blend into the existing gender structure. In reference to their positive transitioning experience, Participant 3 indicated, “I know it’s because I kind of blend in. If I didn’t, I would get crap all of the time. I know I would. That I know. So, I’m very thankful.” Participant 10 demonstrated an understanding of passing privilege, but also acknowledged their concerns about trans invisibility:

This is the irony of TS folk that can successfully transition and pass and go stealth. A lot of them do. And yet that means that we are undercounted and invisible and all of these things. I think that the trans community really still hasn’t found a political voice.

Superordinate Theme 6: Reaction to LGBT connection.

Questions regarding the inclusion of ‘Transgender’ in the LGBT initialism produced
assorted and occasionally conflicted responses.

**Subtheme I: Separating sex and gender.**

The most popular and clearly stated reaction by the participants in this study was that sexual orientation and gender identity are completely separate constructs. For those who are uninformed about the differences between gender identity and sexual orientation, the inclusion of ‘Transgender’ in LGBT can create confusion and inadvertently sexualize transgenderism. As stated by Participant 8, “The other ones are sexual orientations. This is a gender issue. They are not the same thing. I think it causes all sorts of problems.” Participant 19 reinforced the point by stating, “That’s something I’ve had to educate people about quite a bit. People just assumed initially when I went full-time and came out that I was going to start sleeping with men and that hasn’t happened and likely will not happen.” Some participants indicated that as they transitioned and saw themselves differently they began to think about their sexual attractions differently. However, all participants reiterated that gender identity is not about sex or sexual orientation.

**Subtheme II: Advocacy and awareness.**

One of the pros consistently acknowledged regarding the LGBT initialism was the advocacy and awareness that comes with being tied to an increasingly visible and politically recognized community. A number of participants recognized useful political ties, as well as a sense of inclusion, safety, and unity in the face of discrimination. However, many of the same participants also noted friction within the LGBT community, indicating that transgender issues are often overlooked or dismissed in the wake of the gay rights movement. Participant 22 commented on the pros and cons of the LGBT connection:

> So we are in the shadow and that’s fine because we re riding the coattails of, you know, the sexual orientation freedom and anti-discrimination. We are riding that coattail and we
are getting some benefit from it, but we do get shadowed and do get kind of put on the back burner and stuff.

**Subtheme III: Gender discrimination.**

The theme of gender discrimination in the gay community presented itself several times in a number of different interviews. Many participants expressed a belief that the gay community and the transgender community are both being oppressed on the basis of gender. Participant 12 offered their thoughts on the subject:

I think a lot of conflict arises from GBL folks not understanding where gender oppression is happening to them and where oppression that stems from sexual orientation is happening. Like, really effeminate gay men walking down the street, not holding hands with other men, who get bashed; that’s a gender thing. And it’s not necessarily about who they sleep with. But that analysis isn’t very common and so the perception of like mainstream gay folks is that, ‘Well, you know, I’m not experiencing gender oppression. The only people who have experienced that are trans people.’ Um, instead of viewing it as like well, there’s this system of sexism that everyone is experiencing somehow and all of us have this different experience of it, but that definitely creates transphobia and sexism and all these other things.

While broadly discussing experiences of discrimination, Participant 4 came to realize that the bigotry they originally attributed to their sexual orientation was likely due to their gender presentation:

I’m sure I haven't gotten jobs before because I was a big dyke. Um, so like, I would consider that, like discrimination I guess. But it’s not really technically gender related. But if I was a dyke and I didn't (pause) I just looked like a regular stereotypical girl, you know, I think I wouldn't come out and tell anyone about my sexuality. So, I mean, that kind of applies.

The shared experience of gender discrimination presents an opportunity for LGBT individuals to understand how sexism impacts their entire community and to unify in their response to such discrimination. In addition, it may lead to a deeper sense of compassion and understanding within the community itself. Participant 10 stressed the importance of recognition, respect, and unity:
I think that until our own community can get to a place of honoring the diversity and seeing the spectrum, it’s going to be really hard to provide a message to the rest of the world that that’s really what needs to happen.

**Superordinate Theme 7: Healthcare limitations.**

**Subtheme I: Expectation of inferior care.**

When discussing their experiences accessing health care providers, many participants voiced an expectation that they will receive inferior treatment or relayed stories indicating that they already have. Participant 18 conveyed frustration about their inability to find a local physician who would treat them, stating, “You shouldn’t have to go 100 miles one way just to, you know, get basic care.” The same participant indicated that both their therapist and family physician were not qualified to address trans issues. Participant 20 shared their concern about transgender clients being refused altogether:

I do know of people that have been turned down from doctors. They go and make an appointment in their total feminine persona; they have lived that way for years. They walk into the office, the doctor walks in and immediately says, ‘I don’t treat transsexuals,’ and walks out. I know that exists, but I guess that would exist in any profession. I don’t know. It’s sad, but true.

For some, the expectation for differential treatment or adversarial reactions resulted in mistrust and doubt. Many participants asserted that they have tried to minimize their contact with medical and mental health professionals, fearing biased, incompetent, or uneducated providers. In reference to an earlier, unsuccessful attempt to transition, Participant 5 stated, “Back when I tried before, I tried to explain it to the doctor. He didn’t hear me. He thought he was so much smarter than me. Excuse me? No you’re not. I live in this body.” Participant 12 attributed some of the ignorance about transgender issues to the deficiency of adequate research: “The lack of research on trans bodies creates a situation in which really any theory about why transness happens is just as valid as any other.”
Subtheme II: Provider experience, comfort, and competency.

Given the aforementioned concerns about inadequate treatment, several participants endorsed the importance of ensuring that their providers are knowledgeable, experienced, and understanding. Seven participants who indicated they had found such providers all stated that they were “lucky” to have secured quality, competent care. They expressed gratitude for the acceptance, support, and open doors they received. Many agreed that formalized training or experience in LGBT issues would be preferred. For instance, Participant 4 reported, “I definitely would seek someone who is, um, kind of specialized in the rainbow alphabet.”

Participant 20 communicated the value of a mental health provider who respects the client’s expertise of their own experience:

I think the individual knows much more who they are than the psychological community that analyzes them. As a trans-gendered person, all I would ask of you is to listen to what I say, offer me possibilities, but understand that I am in the best position to know who I am. It is my decision to identify as female or to wear female clothes and get a surgical procedure, that is what I choose; it’s my choice and I take full responsibility for that.

Participant 9 noted that they look for a therapist who doesn’t blame or pathologize the individual: “You need someone who is acknowledging the fact that we’re not really responsible for the mental issues created by transitioning. That this isn’t pathological, it’s traumatic.” Similarly, Participant 17 stated that they value a practitioner who doesn’t equate sanity with conformity:

I think it's important for me to know that someone is less concerned about the cause and that the only “fix” is actually to live authentically through your experience and not try to derail it in lieu of some social norm. Because I think that's poison.


Limited resources are available to transgender individuals, particularly outside of fairly progressive cities such as Portland, Oregon. Coupled with the inexperience of most practitioners
regarding gender issues, many participants highlighted the importance of educating themselves about what their treatment should involve. The introduction of the Internet allowed most participants to research available treatment options as well as the changes they could anticipate throughout their transition. Participant 5 declared, “Most of us, we already know. We know what we want to do; we know how we have to do it.” Participant 6 described their experience of gaining self-assurance and advocating for proper care:

It has been pretty seamless and I think a lot of that just has to do with my own comfort with myself because I go in with confidence. I expect the same service I’ve always had. I’ve always been an advocate for myself. I grew up with medical parents. So I think a lot of it is, if you’re not sure of yourself, it’s harder. If you’re not comfortable, it’s harder.

However, even with advocacy efforts, many still have to monitor their treatment for issues that are frequently overlooked post-transition. From MTF prostate exams to FTM pap smears, transgender individuals remain inordinately responsible for their care. Participant 23 spoke about the obligation to educate one’s self and their providers:

I feel like a lot of the people that I have talked to, they’ve heard you know “trans” before but they’ve never really looked it up or looked up what it takes to transition, which makes sense because if you don’t really have to transition, a lot of people don’t look it up. But a lot of mental health people and doctors that I have worked with have no idea, really anything about it other than well; they are changing from one to another. So I’ve had to give out a lot of different copies of Harry Benjamin guidelines and be like, okay, well this is kind of what it is and walk through it with them. Like trying to get my blood work done with my doctor now, because I just passed my two years on hormones, I’ve had to tell her again, ‘Okay well it's my two years I need to get checked for all these things again. I need to be checked because all of these things could happen and it's been a year since I got checked last,’ you know that kind of thing. So kind of having to remind them and help them figure out what the guidelines and what the safe times and distances are you know, and make sure different things get done on time and things like that. So, I think it would just be nice to have a doctor who felt confident or at least did a little bit of research before I ended up working with them. Because it's sometimes hard to go through yourself and also teach doctors to help you, kind of thing.

**Subtheme IV: Gatekeeper model and standards of care.**

Participants conveyed mixed reactions to the gatekeeper model within the current
standards of care. For some, needing permission from a therapist to transition was considered unnecessary and insulting. Based on these concerns, Participant 21 advocated for an alternative treatment model:

I know that system [referring to the gatekeeper system] has been very upsetting for a lot of people um, kind of disrespectful of the fact that you know, transgender and gender nonconforming people are perfectly capable of making their own decisions and should have access to at least the same kind of surgery that other people use to alter their bodies in various ways. Um, I, I have talked to a couple of people who are using um, a new informed consent model um, that some therapists, at least in this area are using, and they seem to have liked that better.

Some believe that having a gatekeeper in place involves seeking permission to be what one already is, which creates tension between patients and providers and may limit the ability to develop a genuine therapeutic relationship. Regardless of one’s certainty about their gender, the physician or psychologist is given the power to make the final decision. The practitioner’s word is therefore greater than the client’s in regards to the client’s own body and experience.

Participant 12 shared their belief that the gatekeeper model contributes to misperceptions about transgender identity:

If I needed to take medication for my asthma, I would not need a letter from a psychologist to get that prescription. I would still need to see my doctor and that's still a gatekeeper model. And I do think that there are blood tests that need to be done to make sure that people are still healthy while they're taking hormones and that makes sense. But to have that process overseen by a psychologist or therapist is just totally weird and I don't get why that has to happen. But it really contributes to misperceptions of trans people as somehow infantile or mentally unstable to the extent that we are unable to make educated and adult decisions about our own care. And that we need to be, the rationale that I keep hearing from the gatekeeper model, like, well we need to make sure that people aren't transitioning all hangily pangily without being sure that this is what they need to do. But I don't hear that same conversation happening around breast augmentation or (pause) people do all kinds of things and they may or may not be mistakes, but that's not the point. The point is that people do what they do and they learn from it. So I think the gatekeeper model needs to be abolished. That sort of feeds into thinking that the DSM shouldn't have trans people in it anymore. There's no syndrome for gay people getting gay bashed. That's just a thing and it's expected that, that if it happens will incur trauma that someone will need to seek therapy for. But that doesn't make it its own special, separate thing. You know, that's just crappy.
Most participants communicated the belief that the gatekeeper model was condescending, using words such as “silly,” “ridiculous,” and “bullshit” to describe it. They argued that clients should have the right to make decisions about their bodies and their medical care. Three participants questioned the relevance of the “real life test,” noting that the requirement is vague and arbitrary given that gender is a unique and personal experience. Others offered a more tempered response to the gatekeeper model. A number of participants noted that they did not find the hoops outlined in the standards of care to be personally problematic, however they still considered them unnecessary or irrelevant. Participant 18 acknowledged the value of assessing for genuine motives, but then stated the following:

I feel ambivalent about it because I think it’s been really badly abused by a lot of practitioners. I think actually the standards of care are set up in a way that is abusive, because it’s requiring this unnecessary level of scrutiny prior to issuing that letter [approving the transition].

A small number of participants viewed meeting with a gatekeeper as a natural part of the transition and appreciated the safeguard in place to screen for contraindicated mental health conditions. Participant 20 stated they were “euphoric” to receive the letter approving hormone replacement therapy, viewing it as a professional confirmation of their internal experience. However, the majority viewed the process as more of a hassle and a hindrance than a necessary precaution. Participant 1 shared their perspective:

I can understand that the medical community wants people to be sure about things, but um, people aren’t usually wishy washy about gender. I mean for most cisgender people they just live out their lives and that’s the way that they live and that’s fine. But for transgender people, it’s something that they’ve known for years. It’s not something that they really have much in the way of second thoughts about.

Later, Participant 1 communicated uncertainty about the efficacy of the current system:

I mean even after say three months, if the therapist says for some reason, “No, I don’t think you are transgender.” Well, then you’re kind of screwed. It just strikes me as odd that someone other than you would know what’s going on inside your head better than
you would I guess. I guess the main thing for me is just that, I can understand the desire to avoid false positives, but I don’t think that people go into this on a whim. I don’t think there is that high of a chance for it.

**Subtheme V: SRS and FFS.**

The decision to pursue SRS and/or facial feminization surgery (FFS) produced varied responses. However, most agreed that it is an individual decision that differs for everyone and should be made with significant consideration. Discussing gender-related surgeries produced concerns regarding the gatekeeper model, as previously reviewed. Participant 1 spoke about SRS in comparison to other forms of body modification:

I mean to pick a different type of surgery, say breast augmentation, that’s something where there is obviously a consultation with the doctor and so on, but as long as you have the finances involved and you meet the physical health requirements for the surgery, generally the patient is allowed to make that decision for themselves. And so I see SRS and those types of surgeries as not necessarily the equivalent to every other plastic surgery, but in my mind certainly closer in scale. Given that the patient would be presumably aware of the risks, but on top of that just the enormous financial cost is its own deterrent in a way. For someone to still want to go through with it seems to indicate that this person really saw no other option then to go about that.

Participant 7 reiterated the absurdity of SRS requirements based on the unlikelihood that the decision is made erroneously:

Somebody who has the surgery because they think that’s what they want and they realize that’s not what they want or they change their mind or something (pause) that’s somebody who is confused. Let’s make that diagnosis, ‘Confusion.’ That’s hard, but those are so few and far between.

Participant 9 reported that they traveled internationally for FFS to avoid the requirements imposed on transgender individuals in the United States.

There was an extensive range of responses from the participants in this study regarding whether they deemed surgery a necessary part of their transition. This was a particularly interesting finding, given the emphasis that is placed on physical treatments for individuals with a medical diagnosis of transgenderism or a psychiatric diagnosis of GID. Participant 22 shared
their outlook on SRS: “It’s a positive yes. Completely, you know, no question about it. I will when I’m ready and I’m financially capable and you know, get over the nerves and everything else. But you know, it’s a definite yes for me.” Participant 15 also endorsed SRS as an important part of their transition:

I could not live with that thing hanging there between my legs. That’s one of the biggest things as I was growing up, especially getting into my puberty years. I kept thinking, fall off and just go down the drain, I don’t want it. So um, when I had the surgery, it was just uplifting. And then I kept thinking, well maybe I need to do something with my face and stuff like that, you know. When somebody noticed the Adam’s apple I decided, okay, let’s get that fixed. When that was fixed, that really made the difference. So those two things just gave me all the more confidence and I don’t worry about anything anymore.

Similarly, Participant 2 stated:

I had to do the surgery. I know there is a lot of folks that don’t feel the need to do that and that’s okay for them. But for me, it was really important to get rid of all of that. And I did.

When reflecting on their surgeries, Participant 2 shared what they deemed most important:

Um, in the beginning I thought that I wouldn’t feel like I’d done anything until I had the actual reassignment. But now that I’ve had all of it done, I can tell you that the number one, most important surgery was the top surgery. The bottom surgery, of course, that was great. But the top surgery is so, huge. It’s huge to the outside world, it’s huge to you, it’s huge for comfort. I mean all of the binding and strapping and all of that crap, I mean what a pain in the butt!

For those who endorsed the personal importance of SRS, they expressed feeling whole, aligned, and physically congruent post-surgery. Others stated that they grew comfortable with their body following hormone replacement therapy and opted to not pursue surgery. Some stated that they were inconvenienced by their genitalia enough to warrant surgery; others mentioned that it was a minor nuisance and not worth the financial and physical strain of surgery. A few participants stated that safety concerns played into their decision to have surgery. Participant 9 indicated that they were content with their body following FFS, but will pursue SRS for social and documentation purposes:
I would say that I was ambivalent about it. I'm fairly content with my body as I am right now, precisely because SRS will not allow me to get pregnant so there's not (pause) you know. My body is mostly okay. But there are documentation issues; there is social respect. I want to sail around the world someday, you know, and I don't need to get strip searched by customs in Tanzania being pre-op, you know, something like that. So, I mean, in a sense I was ambivalent about it enough that it was practical considerations like that that pushed me in favor of it. Because those practical considerations exist, I know that I won't regret it or have any hesitation about it. I'm doing it either way, because ultimately when you get down to it, it is primarily an issue of one, how the world sees you and two, of um, sexual interaction. In both cases, um, though the inertia might keep me okay with how I am now, I legitimately prefer to be truly seen as fully within the female form in those areas. But if it wasn't available, I would be quite content with my life as I am right now. And I have been quite content in terms of um, sex with how I exist now. It's always been a very strictly passive role, but that's quite normal. Um, so, no I don't think, um, that it is some kind of huge event for me. So it's not like a super important thing. I could live as I am now, but in this society there is certainly a feeling that um, it's necessary. Even though I'm going to be just as happy afterwards.

Subtheme VI: Insurance and financial considerations.

Money was the most commonly identified barrier to healthcare, which includes hormone replacement therapy, SRS, FFS, and the psychotherapy required to get approval for such treatments. Participant 20 reported that the gatekeeper model adds an unfair expense to an already costly process:

Having to jump through the gatekeeper, having to go to the gatekeeper for this, I don't agree with that. Because for most people, a lot of us, the thing that stops our transition is financial resources, because it's expensive. If I was going to go to your office and you are charging $100 an hour, my ability to see you for a protracted period of time is limited. If I want the surgical letter to go alter my physical features, I have to come up with it because that is what you feel your education is worth, that's the going rate. I understand that, but the gatekeepers tend to throw a monkey wrench into things, a financial monkey wrench. I know what I am. I cannot afford to spend $3000 or $4000 on psychiatric help to have you tell me what I already know, in order for you to give me a letter.

For many participants, the ability to transition was dependent on their financial resources. Participant 2 commented on the power of money to aid their transition:

I took out the entire amount of my retirement for this transition. I had a sizable chunk of change to do what I needed to do. It’s amazing what you can do if you have money. It’s incredibly amazing what you can do. It’s almost sickening. And I had money, so I didn’t have barriers. What is it now, sixty, seventy thousand dollars later? Now that the majority
of that money is gone, now the barriers are coming.

Obtaining insurance coverage was one such barrier later acknowledged by Participant 2:

Trying to access health care, I’ve been turned down for health insurance twice. I was going to pay for my own private health insurance, but I can’t do it. Once they do an interview, find out about the trans stuff, forget it. They won’t even look at you twice.

In reference to their gender-related treatments, Participant 14 noted:

I’ve had a lot of insurance issues and financial issues with that. They don’t take some insurance and they take others. That’s been kind of stressful because I have to pay a bunch of money every time I go for routine visits.

Relatedly, Participant 18 commented on the unfair differential treatment of insurance companies toward transgender individuals:

My health care plan, there is an exclusion just for any services or supplies relating to sex change operations. It’s like any kind of operation that I get is going to be fully on my dollar, even though the same thing is available to people for other problems if they are not trans. So yeah, I have a problem with that, that’s definitely discrimination.

Participant 5 echoed the injustices of the insurance companies; “There’s just no real medial support for us. Even though the AMA said that this should all be covered by insurance, insurance won’t cover it. Most insurance companies do not cover it.” Participant 12 expressed a desire to take action by stating, “I mean, I think ultimately what needs to happen is there needs to be legal action against insurance companies, such that denying coverage to people who are trans isn't okay anymore.”

The unfair hurdle of expensive treatments, particularly given that insurance companies rarely cover them, adds financial stress to any already taxing process and potentially prevents transgender individuals from transitioning altogether. Participant 17 asserted, “For me, I feel like the only barrier really is just money. Hormones are expensive.” Participant 6 conveyed frustration about the inequitable expense for transgender people:

The biggest obstacle is the money. Um, it kind of pisses me off that I had to pay out-of-
pocket for my chest surgery and my girlfriend is getting a breast reduction for free just because they are large. I mean, I am glad that she is getting it, but it shouldn’t cost me either. I never wanted them. I am much happier without them, you know. And I had to go into debt to do it. And the bottom surgery is completely out of reach, unless I hit the lottery.

**Superordinate Theme 8: Gender Identity Disorder.**

GID remains a highly contended diagnosis within the mental health community. However, the GID debate has been largely separated from the voices of the individuals directly impacted by it. The participants in this study offered their opinions about GID and shared how the diagnosis has affected their life.

**Subtheme 1: Question of applicability and relevance.**

An argument in favor of GID is that the diagnosis validates the distress experienced by transgender individuals and provides such individuals with access to medical care. While this perspective seems to be presented with the best of intentions, many participants responded with confusion and exasperation. Participant 18 demonstrated puzzlement about a psychological disorder treated by physical means:

It’s like, okay, you have this mental disorder, so here is what we recommend for treatment. We are going to give you surgery and oh yeah, we will also give you some drugs that are not psychotropic. It’s like, okay, how is this a mental disorder? You know? I have a problem with it.

Several participants rejected the idea that their gender identity was somehow pathological, but acknowledged the necessity of a diagnosis for treatment in the current health care system. They indicated that the diagnosis was not relevant or informative, but viewed it as a means to treatment. A number of participants agreed that if a diagnosis were necessary, they would prefer it to be physical, not psychological. For more participants than not, GID was viewed as offensive, inaccurate, and unhelpful. Many expressed the belief that GID is a socially defined illness, in that the disorder only exists because of society’s intolerance for gender
nonconformity. Arguments in support of the diagnosis seem to break down when insurance companies refuse to cover the treatments the diagnosis supposedly provides transgender individuals access to. Participant 19 offered a parallel perspective:

Um, coming from a healthcare background I'm a little bit confused about it because if it's a diagnosis then the treatment should be covered by every insurance. And if it's something they are going to declassify, then they need to take it entirely out. It seems to be something that was thrown on the books years ago that they just haven't gotten around to getting rid of or nobody just wants to deal with it.

Many participants had a difficult time identifying the benefits of GID for transgender individuals and therefore advocated for the diagnosis to be removed, or at the very least revised. However, little hope was communicated regarding DSM reform. Participant 13 stated that they feel disenfranchised when it comes to the DSM revisions: “Ray Blanchard is on the DSM [V] committee and it’s like, I read the contention and I just feel so powerless. Because it’s like how do I help?” Participant 10 echoed similar concerns about the revisions to be made in the DSM V:

Well first of all, we’ve got somebody on the committee who thinks reparative therapy is okay. Fuckin-eh! I mean that was discredited for the gay community as a treatment a long time ago. And yet there’s somebody that’s on the committee that thinks that’s going to work for trans people? That pisses me off to no end. It’s just shockingly bad.

The majority of participants viewed GID as an ignorant and absurd diagnosis, stating that they are not “crazy” or “ill.” They indicated that it is difficult enough to be transgender in a binary world, without the added stigma of a mental disorder. Participant 3 responded in anger, stating, “It's preposterous. It's absolutely insane. There's absolutely nothing wrong with us. Nothing wrong with us. We got screwed at birth. That's the bottom line.” Participant 6 voiced their belief about GID in relation to a continuum of gender:

I don't think it should be a mental illness. I really don't. Because I think there is a lot of things that are a continuum. There is a continuum of heterosexuality to homosexuality. There is a continuum. I think, of just sexuality. How feminine do you feel versus how masculine do you feel? I think that we all have a little of both in us, it's just a matter of what's predominant. I think society has put some boundaries around we are going to call
this ‘boy’ and call this ‘girl.’ I would be dying to know if there are societies, you know, other cultures around the world, where there are things that are more feminine that are considered masculine. So I don't think it should be a mental illness. I definitely don't.

Participant 5 argued that pathologizing alternative gender identities contributes to misconceptions about gender and reinforces biased beliefs. They stressed the importance of education and awareness about transgender issues to separate nonsense from the truth:

Something needs to be done. It needs to be taught in school. I know a lot of people don’t want it taught in school; they didn’t want sex education taught in school either. We do not have an official religion in this country, we have an unofficial one. We need to get away from that and start teaching things the way they really are, not the way we want them to be.

**Subtheme II: Pathology and stigma vs. validation and reassurance**

Few participants were in full support of the GID diagnosis. Those who advocated in favor of retaining GID as a mental disorder highlighted the accompanying relief from the recognition and validation of their experience. The participants who were opposed to the existence of GID emphasized the resulting stigma and judgment. A number of participants acknowledged both sides, but questioned whether a diagnosis is necessary to substantiate the distress transgender individuals often face. Participant 21 noted that GID may provide confirmation for others, but stated that they did not find the diagnosis personally relevant:

I think for a lot of people, it is very helpful. It can be very affirming um, and validating and it can get a lot of people access to the medical care they need. For me, um, just because it feels like such a social thing and such a personal thing to do with, not so much um, anything to do with my mental health, but how I relate to my body and how I relate to other people um, I don't think it's very helpful. It wouldn't really express to me anything useful about how I feel about gender.

Similarly, Participant 1 commented on the possible benefits of GID, but questioned the accuracy and applicability:

On the one hand it’s reassuring to have a diagnosis. Having a diagnosis is also something now that I can point my parents towards for example, just to say that it’s not just me.
Other people have given some evaluation to this and so on. But at the same time, um, I mean for example, you don’t have people who are diagnosed as being gay or diagnosed as being left-handed.

Participant 1 later voiced related comments, such as, “There’s a certain sense of being an outsider by having my being be a disorder” and “I don’t feel bad for being transgender, it’s just who I am.”

If a GID diagnosis remains a necessary prerequisite for hormone replacement therapy or SRS, then any transgender individual who is physically transitioning will have to first be considered mentally ill. According to Participant 12, “Getting away from pathologizing transness needs to happen and I'm not sure how to do that if it's still in the DSM.” When describing their required visit with a therapist for HRT approval, and thus a diagnosis of GID, Participant 3 stated the following:

She's not telling me anything I don't know. She's not going to talk me out of this, if that's what she's trying to do. And it's pretty obvious to me what the situation is. So, what is she going to do? Label me crazy? If that's what she wants to do, I don't care. It doesn't help me any.

**Superordinate Theme 9: Post-transition considerations.**

**Subtheme I: Documentation issues.**

The majority of participants noted that issues with documentation are particularly problematic for transgender and gender nonconforming individuals. Gender permeates any and all means of documented identification, from passports to credit cards. Presenting as a gender that is mismatched with ones documentation can have social and legal ramifications. Participant 14 described their issues with documentation in an academic setting:

Socially there is a lot of stress. I haven’t changed my name yet, so I have to e-mail my professors and tell them to use the right pronouns and stuff like that. And it’s just like a whole big mess. It’s really stressful.

Participant 22 described one of the many possible social stressors:
If you have to go into a bar, that’s always interesting, because my picture is from a number of years ago when I had a little shorter hair and stuff. I still had makeup on and everything, but I do still look quite a bit different, so they do this double, triple look.

Participant 15 indicated that attempting to change one’s documentation can be a challenge and entirely unattainable for some:

What do I do? I’ve got to get my name changed, how do I go do that? You know? Fortunately in Oregon it’s fairly easy. In a couple of other states, whatever you were born with you cannot change. They will not allow it and that’s really hard.

Participant 4 described an experience underscoring the idea that gender is socially defined. Despite offering the DMV their assigned gender, the DMV based Participant 4’s documentation on their presentation:

The DMV decided I was male for me. Before I knew. Um, which is really weird. I circled female, my given name is, um, very female. And I gave them my birth certificate that says I am female. Then I got my drivers license. And I didn't notice it for a while. I figured the M meant like motorist or something. And then I’m like, holy! The DMV thinks I'm a guy! And then that was really funny. Um, because the F and the M keys aren’t really close to each other. Um, but I look like I do. And I, I wonder if someone was just like, “Oh, he messed that up.” Or what happened for that to happen. It was very interesting. Um, so apparently people decide what you are, even if you circle a letter.

According to Participant 17, accurate documentation is extremely important for the transgender community. However, gender nonconforming individuals are still forced to choose between two narrow options:

Being able to be recognized by medical professionals, mental health professionals, and then further by, you know, the DMV and whatever else down the line. To say, okay, we are recognizing and empowering your identity. But that’s still a binary idea, because you can’t get a passport that says no gender. It’s still like a huge deal for me, or any of my friends, to be able to check off the other box.

**Subtheme II: Integrating past and present identities.**

Participants offered varied perspectives about the process of integrating their pre- and post-transition identities. Participant 2 described the integration of past and present as the biggest
challenge of their entire transition:

Believe it or not, the most difficult part of it is now. It wasn’t (pause) when I finally made the decision to leave it was, ‘Okay, I’m leaving.’ When I got here, ‘Okay, I got to figure out what I’m going to do.’ Stressful, but not difficult. What is difficult is now post-op, got my health back, okay what now? Because my last, almost four years, has been defined as this. Everything that I acquired, did, certified in, know what to do, is in that old life. And in order to go into that profession, or go into what that is in my experience of this life, I have to drag all of that with me to prove that I have the credentials, the experience, the education, blah, blah, blah, blah. And quite frankly for me, the biggest obstacle is allowing all of that to be a part of what I have now. One part of it is that it’s toxic; I don’t want to bring any of that with me. The second part is I, um, cannot or will not let any of my prior acquaintances know what’s going on with me for the safety of my family who still lives there.

A few participants indicated that they felt completely disconnected from their pre-transition identity. Participant 22 stated, “It’s very interesting, but I’m almost totally disassociated from my existence prior to transitioning, except for that which I had on the Internet. I certainly don’t even really see myself as the same person.” Others expressed feelings of gratitude for having experienced different gender perspectives that they can use to relate to others, such as Participant 15 who noted, “I’ve been both places.” Similarly, Participant 6 stated the following:

Every now and then somebody who knew me before will say ‘she’ and they will apologize or they’ll get panicked about it if they’re introducing me to someone new. And I’m like, ‘Dude, relax.’ I’m not trying to obliterate my past as a woman because I think that there’s a huge advantage to having been a woman. I feel like I kind of have the best of both sides. Because I can speak some Venus and I can speak some Mars.

Subtheme III: Peace and happiness.

A positive feeling post-transition was the final subtheme endorsed by the majority of participants. Though the process of transitioning varied greatly, the emotional outcomes were strikingly similar. For Participant 5, their transition was accompanied by self-acceptance:

I’m a lot happier person, I’m happier about who I am. Um, I used to get really upset just driving my car. I don’t now; I’ll get there eventually. Just being able to be who I am and I wish to God I would’ve done it 20 years ago. But times are changed and people are more
accepting now. And that has been the biggest thing for me, even without the HRT. I’m more accepting of myself and who I am.

When describing the benefits of transitioning, Participant 3 stated, “Peace of mind. Um, calmness. My blood pressure was always high my entire life, until I transitioned, and now it’s normal. I was on blood pressure medication. Um, just health alone.” Several participants responded in the same vein. Participant 10 noted, “I’m open. I am free.” Participant 6 highlighted both emotional and psychological benefits: “It corrects things for me emotionally; it corrects things for me mentally. I’m less anxious about it all. I’m happier where I am now. I have absolutely no regrets about my choice.”

Transitioning presented an opportunity for Participant 10 to question their understanding and experience of gender:

Some of the real benefits to me have been, um, having examined my life and being more sure of who I am and what I want. Um, I think a lot of people go through life not questioning their gender at all. And I think they sort of unknowingly limit their own lives. They certainly limit other peoples’ lives by doing that.

A sense of contentedness and completion was described by Participant 7, who stated that their transition involved, “The coming together as the one person that I’m supposed to be.” Some participants found themselves surprised by their experience post-transition, such as Participant 11 who noted, “The one thing I didn’t expect was this really powerful feeling of serenity.” Participant 19 expressed a sense of relief when they were able to escape the pressure of adopting a gender presentation that never quite fit:

I feel better about myself, I feel more in tune with, more comfortable with myself, more able to express myself the way I want to without having to conform to this societal idea of what a man is supposed to be, because I never was.

The transition allowed Participant 18 to experience honesty and intimacy for the first time in their life:
The benefits of transition are like; it's like being at peace with yourself. The best benefit of transition is loving myself. The second best is the ability to truly be intimate with another human being. Because before that, before I transitioned I could never be fully intimate with anyone sexually or otherwise. I mean okay, so I could have sex and I did have some really good sex and really good intimacy with my co-parent. But it was never a full intimacy because you can't be completely intimate without trust and by definition if I'm not telling her that I'm a woman, I'm not trusting her. I'm lying to her, you know, or at best deceiving her. Um, so it's like, transition made it possible for me to be honest.

Participant 16 was unique in that they expressed regret about their transition. They stated that they made the decision in a haze of medication and psychological pressure. They also indicated that the transition resulted in the loss of their family, which they mourned deeply. Even so, Participant 16 shared the following about their feelings post-transition:

Once in a while I will start on the path of, not very often, but I will start down the path of ‘If I hadn’t transitioned, if I still had my family, if I…’ you know, that senseless bullshit that you need to just get over, you know? And um, and she [referring to her roommate] will tell me, she will ask me, ‘Are you happier now personally as a woman than you were as a man?’ And I have to answer yes. I am much happier. I am much more spontaneous, I don't get depressed so much, I'm more friendly, I'm more socially, I’m more comfortable socially. You know what I'm saying? And all that. So it makes all this complaining and whining about having lost my family seem pretty lame. I recognize the incongruence in my complaining about it, but I was just so attached to them.

As a closing narrative example, Participant 17 remarked on the advantages of granting all individuals the right to genuine fulfillment: “I'm doing my best to be a productive happy person. You know, that makes society a better place for having honest, authentic people.”
Table 3  Superordinate Themes and Subthemes

<table>
<thead>
<tr>
<th>Superordinate Theme 1: Period of questioning</th>
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<td>Subtheme I: Denial</td>
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<tr>
<th>Superordinate Theme 2: Importance of support</th>
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<th>Superordinate Theme 3: The binary myth</th>
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<td>Subtheme I: Complexity of gender</td>
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<td>Subtheme III: Managing language</td>
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<th>Superordinate Theme 5: Trans Visibility</th>
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<td>Subtheme I: Blending in the binary</td>
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<td>Subtheme II: Passing privilege</td>
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<th>Superordinate Theme 6: Reaction to LGBT connection</th>
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<td>Subtheme I: Separating sex and gender</td>
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<td>Subtheme III: Gender discrimination</td>
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<th>Superordinate Theme 7: Healthcare limitations</th>
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<td>Subtheme I: Expectation of inferior care</td>
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<td>Subtheme II: Provider experience, comfort, and competency</td>
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<td>Subtheme III: Personal responsibility for treatment</td>
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<td>Subtheme IV: Gatekeeper model and standards of care</td>
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<td>Subtheme V: SRS and FFS</td>
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<th>Superordinate Theme 8: Gender Identity Disorder</th>
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<td>Subtheme I: Question of applicability and relevance</td>
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<th>Superordinate Theme 9: Post-transition considerations</th>
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<td>Subtheme I: Documentation issues</td>
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Subtheme II: Integrating past and present identities
Subtheme III: Peace and happiness
DISCUSSION

The broad aim of the present study was to improve the understanding of transgender and gender nonconforming individuals. More specifically, the hope was to address the unique treatment considerations of this population. A qualitative design was selected with the intention of allowing members of the transgender community to voice their needs and concerns. In the discussion section I reiterate the original research question categories, review the results, compare the results to previous literature, examine the strengths and limitations of the study, discuss the implications of the findings, and offer recommendations for future research.

The participants were guided through a series of questions related to their gender identity, which included inquiries about their personal conceptualization of gender, the process of transforming their gender expression, their perceived or experienced risk factors and vulnerabilities, their experience accessing services, and their opinions about GID. An exhaustive list of interview questions can be found in the method section.

Review of the Results

Participants relayed information about their gendered experiences by answering an array of open-ended questions. Though the time range varied drastically, all participants endorsed a period of time spent questioning their assigned gender. With such questions came feelings ranging from fear and bewilderment to assurance and excitement. For most participants, this period was resolved through a process of self-reflection and experimentation. Understandably, participants emphasized the importance of support in the process. They underscored their reliance on friends, mentors, and community for understanding and encouragement during the taxing period of transition.
While the difficulties were not always identical, all participants experienced their fair share of challenges. A thorough, though certainly not exhaustive list of obstacles referenced by the participants in this study includes navigating gendered spaces (e.g., bathrooms, support groups), coming out, coping with the loss of relationships, managing language (e.g., changing pronouns), combatting sensationalism, attempting to pass, transitioning in a binary system, coping with pathology and stigma, reconciling past and present identities, receiving inferior or inequitable health care, affording HRT/SRS/FFS with little or no insurance coverage, obtaining appropriate documentation, and enduring prejudice, discrimination, and violence. Even with such an incredibly daunting record of challenges, the majority of participants were unfazed. They demonstrated unwavering resilience, bravery and strength as they took the necessary steps to live honestly.

It was hypothesized that the participants would report that a GID diagnosis was more of a hindrance than an aid. Few participants spoke in favor of the diagnosis. Those who did felt it legitimized their experience to others. Those same participants did not align with the notion that gender identities outside of the socially sanctioned binary are synonymous with mental illness. A number of participants agreed that if a diagnosis were necessary to receive treatment in the current health care system, they would prefer it to be physical, not psychological. Support for any diagnosis seems unfounded, however, when insurance companies refuse to cover the treatments a diagnosis supposedly provides transgender individuals access to. The majority of participants were either confused or utterly offended by the GID diagnosis. They shared the belief that GID exists solely because of society’s ignorance and intolerance for gender nonconformity. Overall, the original hypothesis appeared to be supported, as most participants referred to the GID diagnosis as absurd, inaccurate, biased, and stigmatizing.
It was also hypothesized that the majority of participants would report that medical and mental health communities are limited in their ability to provide competent and affirmative services due to their adherence to the culturally dominant binary system of gender. GID is one example of how the field of mental health currently protects and upholds the binary model, making it impossible not to pathologize any alternative expression of gender. The majority of participants voiced the expectation that they would receive substandard health treatment or imparted stories demonstrating that they already had. Some postulated that the lack of adequate research about the transgender experience results in incompetent or uneducated providers. Almost all participants endorsed the importance of locating providers that are knowledgeable, experienced, and understanding. However, those who believed they found such providers recognized that they are not easy to come by and considered themselves fortunate.

A number of participants expressed the belief that the gatekeeper model in the current standards of care interferes with equitable and quality treatment. Seeking permission to be who one is was perceived by most as condescending, insulting, and irrelevant. Even those who were not particularly bothered by the requirements outlined in the standards of care found them unnecessary. The most commonly held belief by the participants was that as informed and consenting adults, they should have the final word about their bodies and their medical care.

Comparison to Previous Research

The methodology of this study most closely resembled that of Gagne, Tewksbury, and McGaughey (1997). Similar topics were discussed in the interviews with comparable results. Novel questions were also introduced, which moved beyond early life experiences and identity reconciliation into health care treatment and post-transition considerations. Akin to the findings of Gagne et al. (1997), the results of this study indicate that transgender individuals are strongly
compelled to present as their authentic gender, despite social, legal, and political attempts to regulate their gendered experience. Many participants explained that the desire to express their genuine identity was consuming and undeniable. Gagne et al. (1997) suggested that gender identity is confirmed through social recognition, which drives the desire for social expression. This idea was supported by the number of participants in the present study who endorsed wanting physical modifications that allowed them to pass (e.g., hair removal, FFS, top surgery) more so than genital reconstruction.

Further analogous findings include feelings of shame and confusion for engaging in cross-gender activities in childhood, a sense of relief and improved self-understanding upon discovering other transgender people, reliance on community support for identity exploration and resolution, and for most, an adherence to traditional gender presentations given the limited range of socially sanctioned gender identities. Participants acknowledged an increased risk of abuse if they did not conform to the gender binary and attempt to pass as male or female.

In regards to GID, the majority of the participants in this study stood in opposition of the position adopted by the APA. While the DSM has consistently approached gender from the stance that a psychiatric condition is signaled when sex and gender do not correspond, the results of this study suggest that gender is far too complex to be defined by one’s genitalia. Following their interviews with 65 transgender individuals Gagne, Tewksbury, and McGaughey stated, “Our data suggest that gender is not a natural and inevitable outgrowth of sex” (1997, p. 504).

Participants in this study generally agreed with Ault and Brzuzy (2009) who argued that psychiatric diagnoses should not be treated primarily by physical means. A commonality with Ault and Brzuzy (200) also surfaced in regard the belief that the rejection of societal norms is not a justifiable foundation for a mental disorder. Drescher (2009) suggested that the inclusion of
gender diagnoses in the DSM be reevaluated as attitudes evolve, which suggests that societal
standards are at the heart of GID. The current findings imply that labeling gender nonconformity
as disordered at the very least suppresses self-exploration, but may also stimulate reactions of
discrimination and violence. Lombardi (2001) reported that discrimination or violence was a
reality for more than half of all transgender individuals, which was regrettably confirmed by the
participants in this study.

Korell and Lorah (2007) summarized seven actualities specific to working with
transgender people. The participants in this study directly confirmed five of the seven outlined
ideas. The experiences described by the participants highlighted the notion that the majority of
clinicians are limited in their knowledge and understanding of transgender issues, as well as their
competence working with transgender clients. It was also confirmed that gender identity does not
dictate sexual orientation, that transgender clients seek therapy for reasons beyond their gender,
and that SRS is not always the goal of transgender clients accessing services. Lastly, the
participants substantiated the view that alternative gender identities are not synonymous with
pathology.

**Strengths and Limitations**

This study explored gender nonconformity from a phenomenological lens. The a priori
hypotheses were formulated solely from the findings of previous research. Therefore, one
strength of this study is that the participants’ point of view was reflected, rather than the beliefs,
opinions, or potential biases of the researcher. Another potential strength of this study is that
participants were asked in an open-ended forum to self-identify their gender. In previous studies,
gender nonconforming individuals have had categories levied upon them in an effort to
understand the typical transgender experience. Unfortunately, this has likely perpetuated the
assumption that there is a typical experience of gender. By allowing participants to self-identify, this study conceivably lessens the risk of such assumptions and highlights the array of gender possibilities. Additionally, this study contributes to an understanding of GID from the perspective of the individuals who receive the diagnosis. The debate on GID thus far has had a glaring absence of information about the impact of the diagnosis from the affected population’s viewpoint.

The varying ages, ethnicities, gender identities and education levels of the participants potentially could have limited the commonality of responses. However, this did not appear to be the case. The experiences, views, and attitudes expressed by the participants were strikingly similar and are likely generalizable to people who identify somewhere along the wide spectrum of gender nonconformity. It is possible that the results are not transferrable to other geographic locations because participants self-selected to participate and were recruited exclusively from Portland, Oregon (though some phone interviews were with participants who had since moved elsewhere). Many of the positive reactions regarding medical and mental health treatment were specific to Portland providers and may not be transferable to other locations. Another possible limitation related to participation on a voluntary basis is that individuals who had positively resolved their gender identity may have been more willing to speak about their experience than individuals who had not. Nevertheless, it seemed that the majority of participants offered a balanced view of the hardships and rewards of transitioning.

**Implications**

The results of this study indicate that transgender and gender nonconforming individuals feel largely confined and unfairly classified by the GID diagnosis. Physical modifications are widely condoned as an appropriate treatment for the psychiatric disorder, yet the results of this
study imply that not all transgender individuals feel the need to pursue SRS, FFS, or even HRT. Similarly, for those who do wish to modify their sex characteristics to match their gender identity, they must first be deemed mentally ill. The present findings indicate that GID pathologizes gender identities that do not fall cleanly within the binary. Rather than challenging society with the task of expanding their concept of gender, it appears that transgender individuals are asked to fit an incompatible mold and are considered disordered when they cannot or will not do so.

**Directions for Future Research**

The current study revealed that gender identity is a complex and evolving concept. Unfortunately, exploring the complexities of gender is generally discouraged by the dominant culture’s rigid adherence to a binary system. Nevertheless, the participants in this study refused to be confined or pathologized by a two-gender system. Many shared their belief that GID was an unwarranted diagnosis that misinformed the treatment of transgender clients. Further research into the benefits or detriment of GID as a diagnosis may stimulate possible revisions or warrant removal from the DSM. The qualitative nature of this study contributed rich and valuable information to the current body of literature on the multifaceted experience of gender nonconforming and transgender individuals. Continued efforts are needed to diversify transgender literature by exploring the intersection of gender identity with other identities (e.g., racial identity).

**Conclusion**

The voices of the gender nonconforming community have been underrepresented and frequently misunderstood in social scientific literature. The purpose of this study was to inform the treatment of gender nonconforming individuals by interviewing them directly. The
participants in this study described their struggle and pain, but they also highlighted their resolution and joy. They spoke of the rejection of some, but delighted in the embraces of others. They acknowledged their distress, but refused to be defined by it. A large majority of the participants in this study rejected attempts to equate their gender, a fundamental part of their identity, with pathology. Consistent with previous literature, participants largely endorsed the belief that gender is not a product of one’s sexual organs and therefore cannot be assumed to follow suit. It is encouraged that further research be conducted about the potentially deleterious effects of GID on the population that it is intended to serve.
References


British Association for Counselling and Psychotherapy (2007). A systematic review of research on counseling and psychotherapy for lesbian, gay, bisexual, and transgender people. London: British Association for Counselling and Psychotherapy.


Appendix A

Dear potential research participant:

I am seeking your assistance with my dissertation study by inviting you to participate in a study about mental health treatment considerations for transgender people. The Pacific University Institutional Review Board has approved this project. The results of this study will be used to fill in gaps related to the unique needs of the transgender community and will inform providers about how to appropriately and effectively serve gender nonconforming individuals.

The scientific community remains focused on understanding why someone doesn’t fit in male or female categories, rather than viewing gender in an entirely different way. There is a lack of research related to alternative gender identities. Assumptions made regarding transgender individuals may directly harm members of the transgender community or prevent them from accessing medical and mental health services altogether.

You are eligible to participate in this study if you (a) are 18 years of age or older, (b) identify as transgender or gender nonconforming.

Your participation would involve 45-120 minutes of your time in an interview with the primary investigator. You would be guided through a series of questions related to your gender identity.

Participation in this study is completely voluntary, and you may discontinue participation at any time without penalty. If you choose to participate in this study, you will make a significant contribution to research that may enhance professional practice with prospective clients from the transgender community. Your contribution may enable psychologists to develop and apply more effective methods for working with gender variant clients. There are no known risks or benefits to participating in the study.

Sincerely,
Staci Wade-Hernandez
staciwade@pacificu.edu
Your voice can contribute to gender research

You are invited to participate in a research study about mental health treatment considerations for transgender people. The results of this study will be used to fill in gaps related to the unique needs of the transgender community and will inform providers about how to appropriately and effectively serve gender variant individuals.

- Voluntary and anonymous
- Must be 18 years or older
- If you identify as transgender or gender variant and are interested in participating in this study, please contact Staci Wade-Hernandez for more information.
- staciwade@pacificu.edu

Be Heard
Appendix C

1. Study Title
Diagnosis and Treatment Considerations for Gender Nonconformity: Progressive or Pathological?

2. Study Personnel

<table>
<thead>
<tr>
<th>Name</th>
<th>Staci Wade-Hernandez, M.S.</th>
<th>Johan Rosqvist, Psy.D.</th>
</tr>
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<tbody>
<tr>
<td>Role</td>
<td>Graduate Student Investigator</td>
<td>Faculty Advisor/Dissertation Chair</td>
</tr>
<tr>
<td>Institution</td>
<td>Pacific University</td>
<td>Pacific University</td>
</tr>
<tr>
<td>Program</td>
<td>School of Professional Psychology</td>
<td>School of Professional Psychology</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:wade5922@pacificu.edu">wade5922@pacificu.edu</a></td>
<td><a href="mailto:rosqvist@pacificu.edu">rosqvist@pacificu.edu</a></td>
</tr>
<tr>
<td>Telephone</td>
<td>503-713-3155</td>
<td>503-352-2405</td>
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</tbody>
</table>

3. Study Invitation, Purpose, Location, and Dates
You are invited to participate in a research study about mental health treatment considerations for transgender people. The project has been approved by the Pacific University IRB and will be completed by June 2011. The study will be conducted by Staci Wade-Hernandez and Johan Rosqvist and will take place at community agencies in Portland, OR and Hillsboro, OR. The results of this study will be used to fill in gaps related to the unique needs of the transgender community and will inform how to appropriately and effectively serve gender nonconforming individuals.

4. Participant Characteristics and Exclusionary Criteria
Only participants who meet the following conditions will be included in the study: individuals 18 years or older, fluent in English, and self-identifying as transgender or gender nonconforming. Participants who do not meet the above criteria will be excluded from the study.

5. Study Materials and Procedures
If you agree to be in this study, we will ask you to participate in a 1 to 2 hour long interview about your experience identifying as transgender or gender nonconforming.

6. Risks, Risk Reduction Steps and Clinical Alternatives
   a. Unknown Risks:
      It is possible that participation in this study may expose you to currently unforeseeable risks (or to an embryo or fetus, if you are or become pregnant).
   b. Anticipated Risks and Strategies to Minimize/Avoid:
The expected risk to participants is minimal. The interview process may address sensitive topics and may present an emotional risk; however, you may decline answering any given question or end the interview at any time. Due to the nature of the data storage there is minimal risk to a breach of confidentiality. There are no other expected physical, social, legal, or economic risks.

In effort to minimize emotional risk, you are encouraged to share only the information that you feel comfortable discussing in the interview setting. You may discontinue the interview process if at anytime you feel uncomfortable. The investigator has mental health referrals available if you encounter any issues that you would like to discuss in a formal treatment setting. You will bear the cost of mental health services if warranted.

In an effort to minimize risk to confidentiality, you will be assigned an identification number that will be listed in the place of your name on the transcribed interview. Only the investigator will have access to the master list that includes both your name and your identification number. This list will be kept in a locked case and password protected on the principal investigator’s computer, which will always be in the principal investigator’s possession. No identifying information will be used in the final report. Once the study is completed in approximately 9 months the master list will be destroyed.

c. Advantageous Clinical Alternatives:
This study does not involve experimental clinical trials.

7. Adverse Event Handling and Reporting Plan

The IRB office will be notified by the next normal business day if minor adverse events occur (e.g., emotional distress) and will be handled as follows: You will be offered an opportunity to debrief and steps will be taken to resolve your distress (e.g., follow-up, mental health referral). You will bear the cost of mental health services if warranted.

The IRB office will be notified within 24 hours if major adverse events occur (e.g., distress that results in crisis) and will be handled as follows: You will be offered an opportunity to debrief and steps will be taken to resolve your distress (e.g., mental health referral, creating a crisis plan). You will bear the cost of mental health services if warranted. If the crisis involves any limits to confidentiality the proper actions will be taken in regard to reporting the issue.

8. Direct Benefits and/or Payment to Participants

a. Benefit(s):
This study is non-beneficial.

b. Payment(s) or Reward(s):
Participants will not be paid for their participation.

9. Promise of Privacy

The records of this study will be kept confidential. Your answers will be digitally recorded by the principal investigator and kept in a locked, secured location. Your name will not be included in your transcribed responses. No specific information with identifying information will be used in the write-up. This informed consent form will be kept separately from any data we collect. At the time of interview you will be assigned an ID number. Only the primary investigator will have access to both your name and ID number. If the results of this study are to be presented or published, we will not include any information that will make it possible to identify you as an individual. All data will be securely stored in a locked file for a maximum of six months following collection. Any potential future use of the data will not include any identifying information.
There are some limits to confidentiality including: reported abuse of a child, elderly, or disabled person; potential harm to yourself or someone else; and if information is court ordered. In the event that any of these issues are reported during the study, they will be reported to the proper authorities.

10. Medical Care and Compensation In the Event of Accidental Injury

During your participation in this project it is important to understand that you are not a Pacific University clinic patient or client, nor will you be receiving complete psychotherapy as a result of your participation in this study. If you are injured during your participation in this study and it is not due to negligence by Pacific University, the researchers, or any organization associated with the research, you should not expect to receive compensation or medical care from Pacific University, the researchers, or any organization associated with the study.

11. Voluntary Nature of the Study

Your decision whether or not to participate will not affect your current or future relations with Pacific University. If you decide to participate, you are free to not answer any question or withdraw at any time without prejudice or negative consequences. If you choose to withdraw after beginning the study, the investigators will own the data collected following your initial consent and prior to your withdrawal from the study, unless you specifically request that your information not be used for the purposes of the study. Upon completion of the study, all interview materials will be owned by the investigators at Pacific University and will be securely stored in a locked file for potential future use. Information will be kept for a maximum of six months following the collection of the data.

12. Contacts and Questions

The researcher(s) will be happy to answer any questions you may have at any time during the course of the study. If you are not satisfied with the answers you receive, please call Pacific University’s Institutional Review Board, at (503) 352-1478 to discuss your questions or concerns further. If you become injured in some way and feel it is related to your participation in this study, please contact the investigators and/or the IRB office. All concerns and questions will be kept in confidence.

13. Statement of Consent

Yes  No
○  ○ I am 18 years of age or over.
○  ○ All my questions have been answered.
○  ○ I have read and understand the description of my participation duties
○  ○ I have been offered a copy of this form to keep for my records.
○  ○ I agree to participate in this study and understand that I may withdraw at any time without consequence.
○  ○ I give permission for the researcher to gather audio data for analysis, understanding that any published reports will not allow others to ascertain my identity.

Participant's Signature Date
14. Participant Contact Information

This contact information is required in case any issues arise with the study and participants need to be notified and/or to provide participants with the results of the study if they wish.

Would you like to have a summary of the results after the study is completed? _____ Yes _____ No

Participant’s Name (Please Print) ____________________________________________

Street Address __________________________________________________________

Telephone ______________________________________________________________

Email _________________________________________________________________
Appendix D

Participant Demographic Profile

Participant ID #:

Age:

Ethnicity:

Education (Highest grade completed):

Occupation:

Natal Sex:

Self-Identified Gender:

Partnership Status (e.g., Single, Partnered, Separated, Divorced):