

Theses and Dissertations

2014

Experiences with formal and informal support: a case study of a female-to-male transgender individual

Jessica Magallanes

Follow this and additional works at: <https://digitalcommons.pepperdine.edu/etd>

Recommended Citation

Magallanes, Jessica, "Experiences with formal and informal support: a case study of a female-to-male transgender individual" (2014). *Theses and Dissertations*. 408.
<https://digitalcommons.pepperdine.edu/etd/408>

This Dissertation is brought to you for free and open access by Pepperdine Digital Commons. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of Pepperdine Digital Commons. For more information, please contact bailey.berry@pepperdine.edu.

Pepperdine University
Graduate School of Education and Psychology

EXPERIENCES WITH FORMAL AND INFORMAL SUPPORT:
A CASE STUDY OF A FEMALE-TO-MALE TRANSGENDER INDIVIDUAL

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Jessica Magallanes, M.A.

February, 2014

Shelly Harrell, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Jessica Magallanes, M.A.

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Shelly Harrell, Ph.D., Chairperson

Robert deMayo, Ph.D., ABPP

Carolyn O'Keefe, Psy.D.

© Copyright by Jessica Magallanes, M.A. (2014)

All Rights Reserved

TABLE OF CONTENTS

	Page
VITA.....	VI
ABSTRACT.....	VIII
Chapter I: Review of the Literature.....	1
A Brief Review of Gender Variance.....	1
Terms and Definitions.....	1
Transgender Culture in America.....	2
Gender Identity Disorder (GID).....	6
History of Diagnosis and Treatment.....	6
DSM-IV-TR Criteria for Diagnosis.....	9
Prevalence and Course of Disorder.....	13
Controversy Surrounding Diagnosis of GID and Reasons for Reform.....	15
DSM-5: Diagnosis Update.....	23
The Female-to-Male Transgender Person.....	23
Mental Health in the Transgender Community.....	25
Treatment Options and Standard of Care.....	25
Support Services and Resources.....	28
The Therapist.....	29
The Client.....	31
Rationale for the Proposed Study.....	33
Statement of Research Questions.....	34
Chapter II: Methods.....	35
Participant Selection.....	35
Procedures.....	37
Data Collection.....	38
Data Analysis.....	40
Chapter III: Results.....	43
Participant: “Allen”.....	43
Brief Background and History.....	44
Gender Identity.....	44
Ethnicity.....	46
Family Relationships.....	47
Personal Conflicts and Resolutions.....	49
Interpersonal Conflicts and Resolutions.....	55
Experiences of Formal and Informal Support.....	58
Formal Support.....	58
Informal Support.....	63

Perceived Areas of Growth for Support Services	67
Formal Support Services	68
Informal Support Services	68
Prominent Themes	69
Avoidance and Invalidation	69
Rigid Boundaries of Gender Expression.....	74
Silence and Compromise	77
Intragroup Dynamics	80
Chapter IV: Discussion	83
Invisibility: Avoidance and Invalidation	83
Rigid Boundaries of Gender Expression.....	87
Silence and Compromise	88
Intragroup Dynamics	90
Issues of Psychosocial Development.....	91
Emerging Hypotheses	92
Limitations and Implications for Future Research.....	92
Limitations of the Study.....	92
Implications for Future Research.....	93
Conclusion	96
REFERENCES	97
APPENDIX A: Glossary of Terms	103
APPENDIX B: Advertisement for Participation in Study	108
APPENDIX C: Scripts: Email Contact With Participant	110
APPENDIX D: Description of the Study.....	114
APPENDIX E: Local Community Resources.....	117
APPENDIX F: Initial Screening Interview Questions.....	119
APPENDIX G: Informed Consent	123
APPENDIX H: Semi-Structured Interview Guide	126
APPENDIX I: NIH Certificate of Completion	131
APPENDIX J: GPS IRB Approval Letter	133

VITA

JESSICA MAGALLANES, M.A.

EDUCATION

- Pepperdine University, Graduate School of Education and Psychology, Los Angeles, CA
APA accredited PsyD Program
Doctoral Candidate
- Pepperdine University, Graduate School of Education and Psychology, Los Angeles, CA
Master of Arts in Psychology
May 2007
- Mount St. Mary's College, Los Angeles, CA
Bachelor of Arts in Psychology; Minor in Sociology
May 2004

CLINICAL EXPERIENCE

- Santa Monica College, Student Psychological Services (Santa Monica, CA)
Post Doctoral Intern
August 2013 – Present
- New Mexico State University, Counseling Center (Las Cruces, NM)
Pre-Doctoral Intern
August 2012 – August 2013
- Santa Monica College, Student Psychological Services & Pico Promise Transfer Academy
(Santa Monica, CA)
Doctoral Practicum Trainee
September 2011 – July 2012
- Community Coalition for Substance Abuse Prevention and Treatment, South Central Youth
Empowered through Action (Los Angeles, CA)
Doctoral Practicum Trainee
September 2011 – July 2012
- Job Corps (Long Beach, CA)
Doctoral Practicum Externship/Trainee
September 2010 – August 2011

- Metropolitan State Hospital (Norwalk, CA)
Doctoral Practicum Trainee
August 2010 – June 2011
- Verdugo Mental Health Care, Adult Outpatient & Advanced Wellness and Recovery Program (Glendale, CA)
Doctoral Practicum Externship/Trainee
November 2009 – August 2010
- South Central Training Consortium / Hope Gardens Family Center (Los Angeles, CA)
Doctoral Practicum Externship/Trainee
September 2008 – June 2010

ADDITIONAL EXPERIENCE

- Pepperdine University GSEP, Writing Support Center (Los Angeles, CA)
APA Reviewer
January 2009 – June 2012
- Video Monitoring Services (Los Angeles, CA)
Billing Representative, Accounts Payable Department
January 2006 – August 2008
- Video Monitoring Services (Los Angeles, CA)
Administrative Assistant
November 2004 – January 2006

PRESENTATIONS

- Poster Session - Formal and Informal Sources of Support for Female-to-Male (FTM) Transgender Persons
The Association for Women in Psychology Conference
March 2012
- Workshop Co-Facilitator - Focus and Flow Interventions and Therapy (FFIT): Empowering Women Through the Energy of Conscious Engagement
The Association for Women in Psychology Conference
March 2012

ABSTRACT

A case study of a 22 year old female-to-male transgender individual was conducted for the purpose of gaining an in-depth understanding of experiences of formal and informal support in relationship to gender identity. The study included background information, three individual interviews, and content of a blog written by the participant. The interviews explored the topics of gender identity, interpersonal/personal conflicts and resolutions, formal and informal support, community, psychological and medical treatment, therapeutic relationships, significant familial and social relationships, ethnicity, religion, and sexual orientation. Data analysis indicated four prominent themes of the participant's experience of formal and informal support. These included: (a) invisibility shown through avoidance and invalidation experienced with both informal and formal support, (b) rigid boundaries regarding acceptable gender identity expression, (c) using silence and compromise in reaction to unhelpful experiences of formal and informal support, and (d) intragroup dynamics of exclusion. The themes are discussed in relationship to current research, emerging hypotheses, and implications for future research.

Chapter I: Review of the Literature

A Brief Review of Gender Variance

Transgender (gender variant) people are part of the complex tapestry of human diversity. The transgender experience is not a phenomenon exclusive to the United States or the American culture (Bartlett & Vasey, 2006; Beam, 2007; Stryker, 2008). It has been documented in cultures across the world, and the experiences and acceptance of these individuals has varied (Bartlett & Vasey, 2006; Beam, 2007; Feinberg, 2006). Social influences and pressure, as well cultural norms and or flexibility of these norms, largely impact the development of an individual's sense of self, self-esteem, and overall psychological health (Bartlett & Vasey, 2006; Israel & Tarver, 1997; Kennedy, 2007; Sanchez & Vilain, 2009).

Terms and definitions. There exists a number of terms in the psychological and sociological literature used to describe or identify the various types of gender variance. This is partly due to the changes and frequency in the use of terms over time. However, it also calls attention to the discrepancy in the use of terms between those within and those outside of sexual and gender minority communities. For the sake of term and definitional consistency, terms used throughout the manuscript are included in Appendix A. It is important to provide a definition of four terms here in order to facilitate clarity in reading the remainder of the literature. First, *transgender* will be defined as an individual whose gender identity as male or female does not match their birth assigned sex (Gay & Lesbian Alliance Against Defamation [GLAAD], 2007). The second term, *gender variant* or *gender queer*, will be defined as not conforming to social expectations of gender expression (University of California, Berkeley, 2013). The third term, *transman*, will be defined as someone whose birth assigned sex was female but who identifies as

the male gender (Fenway Health, 2010). Finally, *cisgender* will be defined as someone whose gender identity and expression are the same as their birth sex (Fenway Health, 2010)

Transgender culture in America. The rise of transgender culture seems to have been built on grass roots efforts from standout individuals committed to building a network and community of transgender people, a community that later rose in public interest through the help of the media. Contemporary organizations amongst the transgender population began in the 1950s and 60s through the creation of social clubs, and limited circulations of transgender publications (Isreal & Tarver, 1997; Stryker, 2008). Due to the governmental and social targeting and general disapproval of this population, these social clubs, such as the Foundation for Personality Expression (FPE) would often hold club meetings at private homes or hotel rooms in order to avoid social scrutiny. However, unlike these underground social clubs, some early publications, such as the short lived *Transestia* magazine, set the ground for later community based organizations promoting an “identity-based minority community” (Stryker, 2008, p. 54).

As the wider American culture began to change in the 1960s and 70s, the transgender community began to mobilize in large cities like San Francisco and New York in response to continued harassment and violence from police officers and civilians alike (Feinberg, 2006; Stryker, 2008). For instance, in 1966 a riot between police officers and gay and transgender restaurant patrons ensued at Compton’s Cafeteria in San Francisco. The riot began after a group of transgender youth refused an employee’s request to leave the establishment, feeling they were being discriminated against (Stryker, 2008). Those involved in the violent event rallied later that year as a community, and seeing a need for a safe space for themselves and their peers created Vanguard, the first gay and transgender youth organization. Other community-based organizations, which were created and run by lay people within the transgender community, saw

the need to strengthen both external and internal community support. They began to connect their organizations with social and government allies, community activists, as well as medical and mental health resources (Heath, 2006; Isreal & Tarver, 1997; Stryker, 2008). One such organization was Conversion Our Goal (COG) that operated between 1966 and 1968. COG became one of the first organizations to offer not only community and peer support, but connected individuals with psychological counseling services, sex reassignment surgery (SRS) and hormone referrals, and new identification cards that included a change of sex to that of their identified gender. Still others provided outreach to young gay and transgender youth who had been rejected by family and friends, helping them to find food, clothing, and a place to live. One such organization, Street Transvestite Action Revolutionaries (STAR), was created and run in 1970 by two transgender people in response to their involvement in New York's Stonewall riots (Feinberg, 1996; Heath, 2006; Stryker, 2008). As organizations began to rise within the community, and research into psychological and medical treatment progressed, largely due to the efforts of the physician Harry Benjamin, key figures within the transgender community began to emerge. One such figure was Reed Erickson, a wealthy philanthropist and an FTM (female-to-male) transgender man who was a patient of Harry Benjamin. Erickson, and a few others like him, invested in the advancement of their community by donating and helping to fund medical and social services (Heath, 2006; Stryker, 2008).

However, in the early 1970s the transgender community experienced a backlash from the gay community, with whom they had allied early on in their struggle. This began shortly after *homosexuality* was excluded from the DSM and therefore no longer regarded as a diagnosable psychological disorder (Heath, 2006; Stryker, 2008). The gay community regarded this milestone as a sort of emancipation from the pathologizing approach of the psychological

community. However, with the work of Harry Benjamin and the progress in treatment for transgender people, the gay community's perspective was primarily that the transgender community continued to be dependent on medical and psychological interventions to "fit-in" with the larger social web (Stryker, 2008). This seemed to be in contradiction to the gay community's fight to free themselves from "medical-psychiatric oppression" (Stryker, 2008, p. 98). The transgender community also received hostile reactions from the feminist movement at the time, who instead saw the goal of smooth transition into a new social gender role as traditional social and gender conformity. They held this as directly conflicting with their own goal of equality, and ultimate break down of the traditional gender roles they believed contributed to the oppression of woman (Heath, 2006; Stryker, 2008).

In the late 1970s and 80s the FTM community began to emerge in response to the resistance they encountered within the larger Gay, Lesbian, Bisexual, and Transgender (GLBT) community. Just as in the beginning of the transgender movement towards community identity, Transmen used the media in the form of locally circulated newsletter publications, film documentaries, and published books to raise public interest and knowledge of their struggle (Feinberg, 2006; Stryker, 2008). Here again key figures within the FTM community began leading the way in organizing services and group support, such as Lou Sullivan, a transman who headed the transgender group named FTM (Feinberg, 1996; Stryker, 2008). FTM later grew into FTM International and remains the largest Transman organization in the world.

Like other forms of media, the invention and growth of the internet changed the course of the transgender movement. Through the use of online communication, individuals across states and cities became able to connect to peers within the transgender community, as well as contact and connect with support organizations and counseling services (Isreal & Tarver, 1997; Stryker,

2008). Websites continue to provide outreach and education across communities. Greater organization and visibility of the transgender community prompted larger concerns and considerations from government policy makers. In 2007 the U.S. federal government passed the first legislation to address transgender concerns, including bills targeting hate crimes (Isreal & Tarver, 1997; Stryker, 2008).

However, even with the growth of awareness about issues concerning transgender people, prejudice and violence continue to be battles that those within the community fight. In the 2008 National Coalition of Anti-Violence Programs (NCAVP) report on anti-LGBT violence, it was reported that the incidents of violence had increased approximately 24% since the previous year, with the largest increase in reports of victimization coming from the FTM population (NCAVP, 2008). The most current 2012 statistics report a fairly consistent incident rate of hate violence (2,016 reported victims), with a 4% decrease from 2011 (NCAVP, 2012). However, homicides due to anti-LGBTQ and HIV-affected persons continue to be the fourth highest incident rate in the history of the NCAVP (25 victims), with half of the total homicide victims identified as transgender (NCAVP, 2012). In addition to homicide, hate violence includes harassment, threats of violence, and vandalism (NCAVP, 2008, 2012). Data from the report found that transgender people were 2.46 times more likely to experience physical violence, and 3.32 times more to experience violence perpetrated by police officers, than cisgender survivors and victims (NCAVP, 2008). This suggests that although the transgender community has made great strides in progressing medically, socially, and politically through the years since first recognized as an area of interest by clinicians, they continue to face prejudice, discrimination, and violence.

One such well-known case of violence within the FTM community is the case of Brandon Teena, a transman born Teena Renae Brandon in Nebraska. A 1998 documentary (*The Brandon*

Teena Story; Berch, 1998) told the story of the murder of this transman. In 1993 Brandon Teena was living in Fall City, Nebraska. On Christmas Eve of that year, John L. Lotter and Marvin T. Nissen, upon finding out about Brandon's transgender identity, assaulted and raped him, and threatened his life if he reported the incident to the authorities. After his escape from Nissen's home, Brandon reported the assault and rape, and visited an emergency room where a rape kit was completed but later lost. Upon learning of the police report, Lotter and Nissen, who were questioned by the police but not arrested due to insufficient evidence, tracked down Brandon at his friend's home, a woman by the name of Lisa Lambert. On December 31st, 1993, Lotter and Nissen shot and killed Brandon Teena, Lisa Lambert, and Phillip DeVine (a friend staying in the home at the time). This story is only one example of the violence suffered within the transgender community.

Gender Identity Disorder (GID)

The description of Gender Identity Disorder (GID) utilized by professionals in the mental health field is described in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text revision* (DSM-IV-TR; American Psychiatric Association [APA], 2000). The DSM-IV-TR is the primary resource used by clinicians for the identification and diagnosis of GID, and essentially describes the condition in which one's gender identity is inconsistent with one's assigned sex. This section will provide a brief overview of the historical and current diagnosis and treatment of GID, an explanation of the controversy surrounding its inclusion in the DSM, and an update of the diagnosis in the very recently published DSM-5 (APA, 2013).

History of diagnosis and treatment. Although cases of cross-gender behavior has been observed and written about across cultures and early in human history, the modern views on transgender individuals began mostly with the Austrian doctor Karl Heinrick Ulrichs (Heath,

2006; Stryker, 2008). Described in a series of books he titled *Researches on the Riddle of “Man-Manly”* published between 1864 and 1865, Ulrichs developed a biologically based theory to explain a phenomena he termed “urnings” (Stryker, 2008, p. 37), which he illustrated with the phrase *anima muliebris virili corpora inclusa*, a Latin phrase meaning “a female enclosed within a male body” (Stryker, 2008, p.37). As an early advocate for transgender rights within the medical field, Ulrichs suggested that because of its theorized biological foundation and “in the name of rational social order that reflected scientific truth” (Stryker, 2008; p. 37), those who express transgender or homosexual thoughts and feelings should not be repressed by government law.

Following this interest and new research in human sexuality and gender, a medical doctor practicing in Berlin by the name of Magnus Hirschfeld cofounded the Scientific Humanitarian Committee in 1897. This organization is considered to be the first in the world dedicated to the social reform for sexual minorities (Heath, 2006; Stryker, 2008). Credited with creation of the term “transvestite” in 1910, he published the first book outlining treatment for cases of transsexualism. Like Ulrichs, Hirschfeld proposed that sexual and gender variance had their origins in biology and therefore “a just society was one that recognized the natural order of things” (Stryker, 2008, p. 39).

As research and treatment progressed both in the medical and psychological field, so did the treatment options for transgender people. In 1910, Austrian endocrinologist Eugen Steinach first identified the impact of *sex-hormones* (e.g., testosterone and estrogen) on changes in bodily appearance and physical vitality (Kennedy, 2007; Stryker, 2008). By the 1930s transgender people were finding ways to acquire pills or injections of these hormones from clinicians in order to aid in their transformation and ability to pass as the opposite sex (Kennedy, 2007).

Additionally, with the invention of anesthesia in the mid 19th century, surgical procedures were no longer likely to end in death, opening up the possibility for reconstructive surgery to alter physical sex characteristics. However, because medical and surgical treatments were usually completed only if warranted by medical need, access to these early forms of SRS depended on the medical field's proclamation that being transgender was a symptom of mental or physical illness (Heath, 2006; Isreal & Tarver, 1997; Stryker, 2008). Changes and advances in the medical field paved the way for the first documented male-to-female genital surgery of Dora Richter in 1931 (Stryker, 2008). Then in 1946, Michael Dillon (born Laura Maud Dillon in 1915 in London) underwent the first female-to-male SRS. Dillon had several procedures between 1946 and 1949, performed by Harold Gillies, a surgeon who had spent much of his career performing reconstructive surgeries for disfigured soldiers of WWII (Kennedy, 2007). However, in order to avoid the increasing controversy surrounding the use of cosmetic surgeries by transgender people, medical records would officially note a diagnosis as an acute hypospadias (e.g., a developmental anomaly in which the urethra opens inferior to its normal location; usually seen in males, with the opening on the underside of the penis; Medical Dictionary), thus making him out to be a man undergoing surgery for cosmetic penile repair (Kennedy, 2007).

With the advancement and changes in medical treatment for transgender individuals came greater interest and controversy within the psychological field, with major figures in this area of research emerging in the 1940s and 50s, including Harry Benjamin, Karl Bowman, and Alfred Kinsey (Heath, 2006; Stryker, 2008). During this time Bowman and Kinsey advised California attorney general Edmund G. Brown that "transsexual genital modification would constitute 'mayhem' (the willful destruction of healthy tissue)" (Stryker, 2008, p. 45). In response to this advice, Brown proposed that any surgeon who performed such an operation

would be subject to possible criminal prosecution, thereby limiting the number of surgeries performed in the U.S. (Stryker, 2008). However, within a few months of the publication of a book titled *The Transsexual Phenomenon* by Benjamin, who advocated for social and governmental reform in favor of non-persecution of the transgender population, the first “sex change” program was established in the U.S. at Johns Hopkins University Medical School (Heath, 2006; Stryker, 2008).

In the 1950s the term *transsexual* had emerged, and by the 1960s and 70s clinicians used the term *true transsexual* to describe individuals with an unusual gender identity development, later dubbed *gender dysphoria syndrome*. In 1980 a diagnosis of *Transsexualism* was included in the DSM-III to describe individuals who (a) reported gender dysphoria, and (b) reported ongoing interest for at least 2 years in changing their sex and gender. It also made a distinction between adolescent and adult presentations.

DSM-IV-TR criteria for diagnosis. DSM-IV-TR describes four primary criteria for the diagnosis of GID. These include: (a) continual gender identification that is opposite to one’s birth assigned sex, (b) feelings of distress in relation to one’s birth assigned sex that (c) is not paralleled with an intersex condition and that (d) causes considerable harm or impairment in various areas of life (APA, 2000).

The first of the four criteria for diagnosis of GID states that the person must describe “A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex)” (see Criteria A, APA, 2000, p. 581). Identity as the opposite gender is observed and recorded differently in adults than in children. For a child to meet Criteria A of the GID diagnosis they must report four of five described symptoms. These include: (a) repeated verbal statements that he or she is or wants to be the opposite sex, (b) a

predilection for dressing in clothing resembling or stereotypical of that of the opposite sex, (c) a continual preference to take on the role of the opposite sex in imaginary play or fantasies, (d) a strong wish to play games or participate in hobbies stereotypical of the opposite sex, or (e) preferring to have friends of the opposite sex. In order for an adolescent or adult to meet Criteria A of the GID diagnosis, they must report: (a) wanting to be the opposite sex, (b) frequently passing oneself off as the opposite sex, (c) wanting to live or be regarded by others as the opposite sex, or (d) feelings of certainty that their own emotions and reactions are consistent with those characteristic of the opposite sex.

In addition to the symptoms included with Criteria A, Criteria B in the DSM-IV-TR states that an individual must also exhibit uneasiness with their birth assigned sex, or experience a sense of incongruity in the gender role of their biological sex (APA, 2000). The sense of discomfort in the gender role that accompanies one's assigned sex is exhibited differently between ages (i.e., adult vs. childhood display of discomfort) and sexes (i.e., male vs. female display of discomfort). APA (2000) describes that in childhood, males who experience discomfort in their assigned gender role are known to make statements concerning thoughts that their genitals repulse them, have wishes or thoughts that their penis would disappear, avoid or dislike rough play, and often refuse toys, activities, and games typical of other male peers. Female children who experience discomfort in their assigned gender role are often described to refuse to sit while urinating, insist that they have or will grow a penis, make statements concerning wishes to not menstruate or grow breasts, and have a strong dislike for typical female clothing. In adolescence and adulthood, individuals who experience dissonance in their assigned gender role are described to be preoccupied with changing and or losing their primary and secondary sex characteristics (i.e., genitalia, reproductive organs, physical appearance, etc.)

through use of hormones, surgeries, or dress or make-up to create physical characteristics that are more congruent with the gender opposite to their assigned sex (APA, 2000). It is also in adolescence and adulthood that an individual is more likely to make statements about beliefs that “he or she was born the wrong sex” (see Criteria B, APA, 2000).

Criteria C of the GID diagnosis further specifies that making a diagnosis requires that an individual does not experience these symptoms concurrently with a physical intersex condition, or an unusual development of sex characteristics including deformity of genitals, reproductive organs, or sex chromosomes or hormones (APA, 2000). However, a person with a concurrent congenital intersex condition who experiences symptoms appropriate for a diagnosis of GID can be given a diagnosis of *GID Not Otherwise Specified* (APA, 2000). Lastly, Criteria D of the diagnosis requires that the previous symptoms cause “significant distress or impairment” (APA, 2000, p. 581) in multiple areas of functioning.

Differential diagnosis. There are other psychological conditions that may mimic, or share similarities with GID, therefore making it imperative to note the distinctions between them. First, because of the degree to which an individual with GID experiences desire to resemble or be the opposite sex, the diagnosis should be distinguished from an individual’s behavior that is not more than nonconformity to stereotypical sex-roles (APA, 2000), such as not fitting into gender norms within a culture, or a female child who can be considered a “tomboy.” Although these nonconforming behaviors are included in the symptoms experienced by transgender persons, it alone does not warrant a diagnosis of GID.

Transvestic Fetishism, a diagnosable sexual disorder diagnosis, also resembles symptoms of GID. Transvestic Fetishism describes behavior in which a heterosexual or bisexual man dresses in female clothing for sexual gratification, which resembles behaviors exhibited by

transgender individuals who often dress or live as the opposite sex (APA, 2000). However, the behavior of dressing in clothing stereotypical of the opposite sex without the experience of feeling as if one is (or should have been born) as that gender distinguishes Transvestic Fetishism from GID.

Lastly, delusional content experienced by individuals diagnosed with schizophrenia may also emulate GID (APA, 2000). According to Borrás, Huguelet, and Eytan (2007), approximately 20 to 25% of cases of schizophrenia include *pseudotranssexual delusions* (p. 176) that can be categorized into four different types: (a) delusions that one stops belonging to their own sex, (b) delusions that one has been neutered, (c) delusions that one concurrently belongs to both sexes, and (d) delusions that one belongs to the opposite sex. The last category (i.e., delusions that one belongs to the opposite sex) most closely resembles GID. APA (2000) suggests that:

Insistence by a person with a Gender Identity Disorder that he or she is of the other sex is not considered a delusion, because what is invariably meant is that the person feels like a member of the other sex rather than truly believes that he or she is a member of the other sex. (p. 581)

The distinguishing factor then between a pseudotranssexual delusion and GID is that, for example, a woman diagnosed with GID has the awareness that although she feels like a male she recognizes that her body is biologically and physically female. On the other hand, a female who has been diagnosed with schizophrenia and is experiencing a pseudotranssexual delusion believes that not only does she feel like a male, but that she is a male both biologically and physically. It should be acknowledged, however, that cases of individuals who have a diagnosis

of schizophrenia and meet full criteria for a diagnosis of GID can occur, although cases are rare (APA, 2000; Borrás et al., 2007).

Prevalence and course of disorder. There is some controversy in recent research on the statistical prevalence of transgender individuals. Typically cited in the media and in psychologically based articles is the APA's estimate of occurrence of transgender people as 1 in 30,000 birth males, and 1 in 100,000 birth females (APA, 2000). However, Olyslager and Conway (2007) suggest that cases of transgender individuals occur much more frequently than this popular estimate. Typically the occurrence of transgender cases has been estimated by the frequency of SRS. According to Olyslager and Conway, using this source for calculation grossly underestimates the actual occurrence of cases because of the many individuals within the transgender population who do not seek out SRS, medical or hormonal treatments, or choose to never disclose their conditions. Furthermore, the accepted difference in the estimate of occurrences of GID between birth males and birth females is also likely skewed; underestimating the occurrence in the female population likely due to the higher referral for treatment of young males compared to young females (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003). Through use of data from surveys and other reports gathering information on the prevalence of GID and services provided in clinics serving the transgender community, Olyslager and Conway developed methods for:

- (i) projecting a more realistic value for the prevalence of SRS in a steady-state population from data during the SRS start-up transient (once the transient has leveled-off), and (ii)
- for projecting the inherent prevalence of the condition leading to SRS by taking into account the average durations of life pre- and post-SRS. (2007, p. 22)

The researchers' recalculations propose that the prevalence of those who can be considered part of the wider transgender community is more likely to be approximately 1:100 or more, or about 1% of the population (Olyslager & Conway, 2007).

The DSM-IV-TR outlines two separate courses of development of GID for adults. The first is the "continuous course" (APA, 2000, p. 580) starting in early childhood and stable through adolescence and into adulthood. In this continuous course, children between the ages of 2 and 4 can be witnessed to have preferences in cross-gender behaviors, typically showing interests and activities typically of the opposite sex (APA, 2000). However, it is noted that only a small percentage of children who display these behaviors at such an early age will continue exhibiting behavior into adolescence or adulthood that warrants a diagnosis of GID (APA, 2000). Parents and guardians typically first seek psychological services for school-aged children whose non-conforming gender behavior may likely continue into the start of school. However, over time cross-gender behaviors appear to wane and become less evident, which is partly due to parental-involvement or pressure from peers. By adulthood, about three-fourths of these children will identify as gay or bisexual, but will not meet criteria for GID. Still, other children continue to have experiences that warrant a diagnosis of GID, and may develop a more defined cross-gender identity.

The second course outlined in the DSM-IV-TR is the onset of cross-gender behavior in late adolescence or in adulthood (APA, 2000). Here symptoms appear to emerge gradually, which may progress into a warranted diagnosis of GID in mid-adulthood. Individuals who exhibit late onset of symptoms exhibit greater variance in the strength of cross-gender identification, show more ambivalence concerning SRS, and are less likely to be satisfied with

their bodies post-SRS (APA, 2000). The DSM notes that cases of “spontaneous remission” (APA, 2000, p. 580) have occurred.

Controversy surrounding diagnosis of GID and reasons for reform. In American history it has typically been the case that those who do not conform to our society’s perception of normality, created and maintained by patriarchal institutions, are ostracized and pathologized for their non-conformity (Ceglie & Thummel, 2006; Feder, 1997; Flowers & Langdridge, 2007; Sanchez & Vilain, 2009; Stryker, 2008; White & Ettner, 2007; Winters, 2006). This can be seen not only with the marginalization of the transgender community, but also with groups of gay, lesbian, and bisexual individuals who have also dared to step outside imposed gender roles (Flowers & Langdridge, 2007). Just as other oppressed populations have, the transgender community has begun their movement to reject and transform the label placed on them as perverse and deviant individuals (Ault & Brzuzy, 2009; Stryker, 2008).

Although the mental health community has, for the most part, spoken against the idea of gender variance as pathological (Bockting & Ehrbar, 2006), the term *disorder* continues to denote to the general public that those labeled with a disorder are “crazy” (Ault & Brzuzy, 2009; Winters, 2006). Furthermore, the idea that in order to be a “normal” person one must conform to social norms consistently pathologizes the transgender person (Feder, 1997; Winters, 2006). The average person is typically not knowledgeable about gender variance and may subscribe to traditional gender-role ideas (Ault & Brzuzy, 2009; Feder, 1997). These people may not think to consider the diagnosis of GID as solely a description of features experienced by transgender people, nor might they view it as a way to communicate the need for treatment (Ault & Brzuzy, 2009; Feder, 1997; Fink, 2006; Levine & Solomon, 2009).

There are several major arguments made by professionals in the field of psychology, as well as advocates within the transgender community, that have argued for the reformation and or removal of the diagnosis of GID. In addition to the arguments made above, many therapists who work within the transgender community have suggested that the diagnosis of GID in the DSM-IV-TR is limited in the overall description of gender variance (i.e., criteria, and developmental course). This, in turn, limits the number of individuals who might otherwise qualify for particular treatments while at the same time including others in the diagnosis who may not be appropriately diagnosed as such (Bower, 2001; Winters, 2006).

Social implications of diagnosis. An article by Flowers and Langdrige (2007) analyzes and describes how discrimination and the pathologization of an undeserved population can continue to appear in contemporary publications. They use a 2004 article written by Crossley as an example. The article focused on narratives of gay men and depicted their experiences as pathological, deviant, and unhealthy. Flowers and Langdrige point out the inadequacy of Crossley's article by outlining how the resources used were carefully chosen so that they support the direction of the article, as well as the grossly overlooked double standard of values and behaviors held for one population of gay men and not for the more general heterosexual population.

Flowers and Langdrige (2007) specifically point out that the descriptions of sexual experiences of some gay men (e.g., anonymous sex, swinging or swapping of sexual partners, fetish parties, unprotected sex, and extramarital sex or cheating) is held as deviant, pathological, and rampant sexual behavior within the gay male community. However, the researchers point out that Crossley's article fails to point out that monogamous sexual relationships are also very common in the gay community. Moreover, all of the sexual practices posed as examples of

sexual deviance can also be observed in the wider heterosexual population, although this comparison is not mentioned anywhere in the analyzed article. Flowers and Langdridge explain how stigma and social norms can be further reinforced by researchers' and clinicians' pinpointing of deviant behavior in a population which then may be used to create overgeneralizations. They further illustrate how unwarranted stigmatization and pathologization can endure even in journals and research that is intended to be consistent with current psychological thought.

An article by Winters (2006) highlights shortcomings of the DSM description of GID, analyzes the usefulness of the diagnosis, and discusses the ways in which it maintains ongoing social stigma. Like many other therapists who have worked with transgender clients, Winters agrees that the diagnosis of GID and the description outlined in the DSM reinforces the idea of gender variant identity and expression as a *disorder* and therefore pathological. Much like the article by Ehrbar, Witty, Ehrbar, and Bockting (2008), Winters brings to light an unaddressed double standard of what is considered normal behavior. For example, she proposes that gender expressive behaviors that would be considered conforming to social and gender roles for a non-transgender woman might also be considered conforming gender expression for a transgender woman due to its concordance with their identified gender. She also points out that ordinary gender expression that conforms to one's gender identity (i.e., dress and mannerisms) is considered to be a fixation and preoccupation for transgender people but not for non-transgender people. Lastly, Winters suggests that reform of the GID diagnosis is needed, but does not propose total exclusion from the DSM. She suggests that GID might be better substituted by a diagnosis in which the focus of clinical attention is long-term and chronic distress, rather than behavioral and social nonconformity.

An article by Fink (2006) gives his professional opinions of the controversy surrounding the inclusion of GID and sexual disorders in the DSM. During his years as a psychiatrist he has evaluated more than 40 transgender individuals for consideration for sex reassignment surgery.

He states that:

Transsexualism is a diagnosis. It is not something that is by choice, and therefore, you do want it to remain in the *DSM*. Furthermore, I do not believe that the diagnosis stigmatizes anyone worse than the stigma the transsexuals receive every single day. (p. 119)

Fink also holds that normalizing and “legitimizing” (p.119) non-conforming behavior as a way to fix the identified problem (i.e., distress associated with social pressure or stigma) would not be “useful” (p.119) for the individual. Here he is referring mostly to the extent to which a parent allows a child to express his or her own identified gender identity. His rationale is that although gender variance may not justify a label of pathology, it is not something that is of benefit to an individual. He explains that, especially in the case of children, non-conforming gender behaviors (e.g., cross dressing, etc.) increases the likelihood and vulnerability of these children to teasing, bullying, discrimination, or social exile from peers. However, these children will be less vulnerable to such possibly traumatic experiences should they learn to engage in behaviors more in line with their birth sex. Finally, Fink admits that there are many questions and controversies concerning the diagnosis and treatment of GID, and whether or not they contribute to the ongoing social views of those who bear this diagnosis as pathological. He states, “I do not know the answer to these conundrums. I only know that I am with the patient as a clinician to help them and having the diagnosis helps me to help them” (Fink, 2006, p. 122).

Although Fink's (2006) article does not seem to directly label gender variance as pathological, he does point out that society sees it as abnormal. Fink also states that there must be a way to distinguish normal from abnormal behavior, or psychologically healthy behavior from damaging behavior, although not suggesting how this is to be done.

An article by Ehrbar et al. (2008) looks at the DSM-IV-TR diagnosis of Gender Identity Disorder in childhood and the current criticism that diagnosis is too heavily focused on gender non-conforming behavior rather than the internal identified gender. The study sought to determine whether a therapist would be likely to diagnose a child with GID who displays behavioral features but does not express clear gender dysphoria, whether a child who displays these non-conforming behaviors might be viewed by a therapist as more pathological than those children who do not, and if differences in demographics and experience of the clinician may have influenced their decision. They attempted to answer these questions by randomly distributing several vignettes to a sample of 73 psychologists, which depicted either a female or male child displaying conforming, moderately non-conforming, or exceptionally non-conforming behavior. Participants were asked to give a DSM diagnosis (if one was warranted) and a Global Assessment of Functioning (GAF) score for each vignette. Only the vignettes describing the exceptionally non-conforming behavior adequately met criteria for a diagnosis of GID.

The study found no significant difference between the frequency of diagnosis between the female and male vignettes (Ehrbar et al., 2008). It also found that participants tended to under-diagnose GID for those vignettes that warranted a diagnosis, and were more likely to give a diagnosis of GID when there was an explicit reporting of a wish to be of the opposite gender. Several participants assigned V-codes in place of diagnoses where the focus of attention was familial conflict. Although not asked to do so, some participants added comments explaining

their choice to not make a GID diagnosis for vignettes they realized met sufficient diagnostic criteria. These included:

1) they perceived GID to be a problematic diagnostic category that should be eliminated, that is sexist and/or homophobic; 2) they did not believe the child met criterion D, indicating distress or impairment; 3) they preferred to use the least stigmatizing diagnosis possible. (Erhbar et al., 2008, p. 14)

Results also showed that GAF scores given to vignettes describing a self-report of a wish to be the other gender were lower than those that described only non-conforming behaviors. In terms of any demographic influences, it was found that non-heterosexual participants were less likely to assign GID to the case than were heterosexual participants.

The spontaneous commentary provided by some of the participants seem to show that there are clinicians who have recognized some kind of stigmatization associated with labeling a child with GID (Ehrbar et al., 2008). These findings might also reflect a self-selection bias of the sample, representing participating therapists who may be more interested or comfortable discussing of issues around gender variance and GID. Some may also in fact view the diagnosis as discriminatory and so consciously decline assigning it to a child who may carry this stigma. The study's finding that non-heterosexual participants were less likely to assign the diagnosis than heterosexual participants may be evidence that what is considered pathological is quite possibly subjective to the clinicians' own experiences and endorsement of conformity as healthy and normal (Ehrbar et al., 2008).

A research article by Haraldsen and Dahl (2000) investigated the idea of transgender individuals expressing pathological behavior by comparing psychological profiles of individuals who fit the diagnosis of GID (n = 99; 35 female-to-male; 51 male-to-female) to individuals who

fit either an Axis I or Axis II diagnosis (n = 101; 27 male; 74 female) and a normative sample of non-institutionalized Norwegian individuals (n = 1068; 522 male; 546 female). All groups had an average level of 10-12 years of education. Psychopathology of all participants were assessed using *The Hopkins Symptom Checklist (SCL-90/90-R)*, and all were given a GAF score. Results of the study showed that there were no significant differences between the transgender sample and the normative sample on any of the measures. In addition, the transgender sample scored significantly lower on the assessment of pathology than the sample of individuals with diagnosable Axis I and Axis II disorders. However, Haraldsen and Dahl suspect that the public resources and comprehensive care services available to the transgender community in Norway may have a positive impact on the levels of psychological distress, thereby increasing the likelihood that the scores of the transgender sample would be comparable to that of the normative sample.

The results of this study imply that the transgender community may show no more pathology than the average population, giving additional evidence that the term *disorder* that they are labeled with when diagnosed with GID is a misnomer (Haraldsen & Dahl, 2000). Thereby suggesting that the healthy adjustment of the transgender community can be accomplished when availability of public resources and comprehensive medical and psychological care is viewed and addressed as an imperative social service (Haraldsen & Dahl, 2000).

Diagnostic deficiencies and limitations. Megeri and Khoosal (2007) studied depression and anxiety symptoms in male-to-female transgender individuals who were receiving comprehensive services at Leicester Gender Identity Clinic in the United Kingdom. This clinic has been providing services from assessment through sex reassignment surgery for transgender

clients since 1994. The participants of this study completed several self-administered tests that scored depression and anxiety levels pre- and post-surgery. So as not to affect treatment and management after surgery, participants were assured that tests would not be scored until 3 years after their operation. The ages of the participants ranged from 23 to 75 years old, and the time range between initial assessment and sex reassignment surgery was 2 months to 6 years. The results of the first 40 participants were presented in this study. Pre-surgery scores showed that no participant had any past psychiatric history. Results did not suggest any significant difference in anxiety or depression levels between pre- and post-surgery assessment. Megeri and Khoosal suggest that perhaps clients wanted to present themselves in a healthy light, which would then affect self-reported anxiety and depression scales, possibly due to fear that it may interfere with their approval for sex reassignment surgery. They also suggest the possibility that these symptoms may have been affected by increased feelings of support related to the comprehensive services provided by the clinic before and after surgery (Megeri & Khoosal, 2007).

Though the data results from the study did not show any significant differences in anxiety and depression levels in male-to-female transgender persons, it does address an important issue. Depression and anxiety are the most common symptoms associated with gender variance because of social stressors, not from the symptoms of GID itself. If this is the case, then the reduction and prevention of these symptoms of depression and anxiety specifically are important to the psychotherapeutic treatment of gender variant people.

An article by Bower (2001) sought to identify omissions and limitations of GID by systematically reviewing the description of the diagnosis in the DSM. Concerning diagnostic features of the diagnosis, Bower addresses the requirement for demonstrated impairment in both social and other functioning. He suggests that social and other impairment is not present in

every client, nor is it always significant. The section that describes associated features and mental disorders includes social isolation, the frequency of anxiety and depression related symptoms, or a personality disorder. Bower suggests that the term *personality disorder* does not accurately describe the experience and development of the transgender person, but that it might be more appropriately termed *personality change* imposed by parental and social pressure on a growing and developing individual. The effect of social pressure on personality change and impairment can often be seen with female tomboys who are generally more accepted than feminine boys, and who may less severe parental and social non-acceptance and pressure to be “normal” thereby promoting less distress in adulthood than their counterparts (Bower, 2001).

DSM-5: Diagnosis update. The APA has recently released its newly published 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013). In this new edition, GID was removed from categorization under Sexual and Gender Identity Disorders, renamed Gender Dysphoria, and is a stand-alone chapter within the manual. The primary change of this diagnosis is the focus on the experience of dysphoria rather than the experience of a specific gender identity. This was done in hopes of better capturing the range of experiences of gender, and to help decrease stigma associated with the term *disorder*, while maintaining the ability to access appropriate psychological and medical care through insurance coverage (APA Factsheet, 2013).

The Female-to-Male Transgender Person

Much of the published empirical articles concerning the transgender population are written both generally and specifically concerning the MTF (male-to-female) type transgender person (Israel & Tarver, 1997). There are several possible reasons for this. One reason is that the MTF population is more likely to participate in psychotherapeutic treatment in their lifetime

possibly because participation in cross gender behaviors may tend to have greater social repercussions for males than for females (Cohen-Kettenis et al., 2003). This may lead to greater experiences of emotional distress (especially in children), depression, and acting out behaviors due to outside pressures to conform (Cohen-Kettenis et al., 2003). Their cross-gender behavior and its social taboo also make it more likely that participation in psychological services will concern gender issues.

However, male characteristics (e.g., assertiveness) and cross-gender play behavior in female children (e.g., playing sports) is not weighted with the same pathology as the latter (Cohen-Kettenis et al., 2003). Female *tomboys* are less frequently seen as problematic, and at times might be deemed as a female strength; therefore adult transgender females are less likely than transgender males to have an experience of psychotherapy in childhood that specifically concerned gender issues. Childhood psychotherapy for transgender females generally concerns issues of depression or behavioral problems that may be fueled by an underlying distress due to internal conflict between their identified gender and birth sex (Ehrbar et al., 2008). Therefore, the larger number of male transgender clients may increase the availability of information in this specific area.

Another reason why psychological literature concerning transgender issues is dominated by a focus on the MTF population might be because they are more likely to utilize hormone therapy, cosmetic surgeries and follow-through with total sex reassignment surgery (SRS; Israel & Tarver, 1997). This may be accounted for by the advances in MTF surgical procedures, which are more likely to result in positive outcomes than SRS for FTM persons (Israel & Tarver, 1997). Cosmetic surgeries may also be more utilized in the MTF population because they are more necessary. FTM individuals can dress like men, bind their breasts, or get male-styled haircuts

that allow them to more easily *pass* as males in the general public (Israel & Tarver, 1997). However, male features tend to be harder to disguise and extra steps often need to be taken in order for them to easily pass as females in the general public. Ultimately, this means that MTF persons are more likely to utilize medical and psychological services in order to be able to enlist these procedures (Israel & Tarver, 1997).

In addition to growing interest from the media in the MTF population, cross dressers, and *drag queens*, the spotlight for social and psychological interest in this specific community appears to also be focused in this special area, which then leaves a gap in the literature specific to FTM individuals in that same community of people (Heath, 2006). Therefore, selecting a female-to-male transgender participant for this case study was decided on in order to contribute to information specific to this population.

Mental Health Services in the Transgender Community

This section will review (a) standard of care for treatment of transgender individuals, (b) availability of support services and resources, (c) the therapist and their role in treatment, (d) and the experiences and motivation for a client as it pertains to psychotherapy.

Treatment options and standard of care. The experience of receiving psychological support and treatment from mental health professionals is an important area to examine given the implications for healthy development. When children display gender non-conforming behaviors that are causing distress between the child and the family or within the child's social environment (i.e., with friends or at school), the treatment plan is generally developed by the therapist in collaboration with the parent's wishes and desired outcome (Fink, 2006, World Professional Association for Transgender Health [WPATH], 2001, 2012). The role of the therapist is to act as a support, not only for the child in his/her personal conflicts, but also to

support and help the child's parent(s) make a decision on the extent to which they allow their child to assume the gender identity they feel is correct (WPATH, 2001, 2012). This means that there is a spectrum of gender variant behaviors in which parents can allow their child to partake. Some parents choose to allow their child to behave in a way that feels most comfortable for the child and work with a therapist to help the family and the child cope with social stressors imposed on them (WPATH, 2001, 2012). Others may allow gender variant behaviors inside the home only, and still others may work with a therapist in implementing behavioral techniques to reinforce and or change the child's behavior and gender expression to that which matches their birth-assigned sex (Feder, 1997).

Treatment guidelines in the U.S. According to the standards of care for transgender clients, primary treatment goals for psychotherapeutic assessment and treatment of children who meet criteria for GID are: (a) support families in developing an “accepting and nurturing response” to concerns of gender dysphoria exhibited by their child (WPATH, 2012, p. 15) and (b) reduce distress related to the gender identity conflict and any other problematic issues while providing continual familial support during the decision making process throughout treatment (WPATH, 2012). Probably the most common treatment engaged in by individuals with GID is the use of psychotherapy to address symptoms associated with depression and anxiety in response to negative life experiences (Isreal & Tarver, 1997). Behavioral treatments for some children may also include techniques to reinforce gender appropriate behaviors (Ellis & Eriksen, 2002) so as to decrease experiences of negative response from peers or in social setting. Physical interventions are also optional for the treatment of adolescents. These include participating in part-time cross-gender behavior, such as cross-dressing or wearing undergarments typical of the other sex in non-public ways or for limited periods of time in order

to create an outlet from which to evaluate their cross-gender desires (Isreal & Tarver, 1997; WPATH, 2001, 2012). Adolescents also have the option of delaying puberty through the use of hormones in order to allow the child to continue to explore their cross-gender wishes and behaviors, or for adolescents with clearer and more intense cross-gender identification, to allow for better resemblance of the opposite sex for future hormone treatments and or SRS (WPATH, 2001, 2012). This intervention is entirely reversible should the adolescent (or parent) choose to follow through in their natural sex development. Only partially reversible is the option for adolescents to begin hormone therapy to either masculinize or feminize their appearance (WPATH, 2001, 2012), which is allowed starting at age 16. Participation in psychotherapy is a requirement for adolescents in this phase of treatment, during which clients also begin the “real-life experience” of living full-time as the opposite sex. Surgical interventions should not be done until the adolescent reaches adulthood (WPATH, 2001, 2012).

The primary treatment goals for psychotherapeutic assessment and treatment of adults who meet criteria for GID are: (a) assess gender dysphoria in regards to psychosocial adjustment that may or may not result in a formal diagnosis; (b) provide discuss treatment options for addressing gender identity and expression, including medical treatments; and (c) assess and discuss treatment options for co-occurring mental health concerns; (d) assess, prepare and refer client for hormone therapy or surgery if applicable (WPATH, 2012). To be eligible for hormone therapy an individual must be at least 18 years of age, be capable of give providing informed consent for treatment, have persistent and document gender dysphoria, and be have reasonable control of any other medical or mental health concerns (WPATH, 2012). For those individuals who decide to undergo SRS, living full-time as the opposite sex and hormone therapy are requirements for eligibility, and surgery must be deemed an intervention that is medically

indicated and medically necessary to relieve symptoms of gender dysphoria (WPATH, 2012). Typical requirements for eligibility for SRS include: (a) show persistent and documented gender dysphoria, (b) be fully capable of giving informed consent, (c) be the legal age of consent, (d) have reasonable control of any other medical or mental health concerns (e) approximately 12 months of consistent hormone therapy prior to surgery, (f) approximately 12 months of ongoing participation of living as opposite sex full-time, (WPATH, 2012).

Although not necessary for hormone therapy or SRS, it is recommended that individuals engaging in these medical interventions, and sufficient documentation of the individual persistent gender dysphoria (including dates of living as the opposite gender) from a “qualified mental health professional” are required (WPATH, 2012, p. 58). This documentation is typically a referral letter indicating: (a) general identifying characteristics, (b) assessment results, (c) duration of the professional therapeutic relationship and type of therapy, (d) explanation of criteria met and referral rationale, (e) a statement indicated informed consent, and (f) availability for coordination of care (WPATH, 2012). One of these referral letters is needed for an individual to qualify for top surgery (i.e., breast/chest), and two letters are needed for qualification for SRS (WPATH, 2012).

Support services and resources. From the beginnings of organization of the transgender community peer support groups, social clubs, local magazines and newsletters, books, and media including internet outreach and communications have served as a major source of support resources for transgender people across America (Isreal & Tarver, 1997; Stryker, 2008). Support and social groups are found to be beneficial especially for individuals who have reported that they have suffered some difficulty with socializing. Typically these forms of communications also serve as a filter through which individuals within the transgender

community seek out and find mental health providers and services (Bess & Stabb, 2009).

Transgender participants in a 2009 study reported that they typically decided on psychotherapy from a therapist who had been referred to them by a friend or a person in their community, through community resources (i.e., support or social groups), or by attending talks by therapists who provided outreach within the community (Bess & Stabb, 2009).

Barriers to treatment. Ault and Brzuzy (2009) suggests that the purpose of the diagnosis is to warrant sex reassignment surgery as the ultimate treatment goal for transgender individuals and points out that this *ultimate goal* is not one that is sought out by all gender variant people. It also suggests that physical bodily alterations should not be considered a *cure* for a disorder, and mentions that this is not the case for any other disorder. Ault and Brzuzy propose that viewing sex reassignment surgery and conforming behavior as a *cure* for this diagnosis is offensive and limiting to developing and evolving gender norms. The article also suggests that the diagnosis was created to benefit and diminish distress of “gender-rigid social institutions and parents” (p. 188) by providing a label for gender variant individuals. Lastly, the article briefly addresses the need for clients to stand against that which reinforces social injustice, stating that, “people [who] struggle with gender and sexuality issues must challenge dominant and historically oppressive beliefs about these systems of social organization, especially when they are encoded in a diagnosis of a mental disorder” (p. 189). Thus, for some individuals seeking psychological and or medical treatment around their cross-gender identification may mean giving into the idea of being labeled “disordered”, which may then create a separate struggle and personal barrier to seeking services.

The therapist. Mental Health professionals who work within the transgender community are often called upon to take on a variety of roles including being community

advocates within and outside of the transgender community by raising awareness of issues faced by the population (Bess & Stabb, 2009). In order to meet the various specialized needs of these clients, therapists may also engage in continual networking and searching for needed resources (i.e., medical program interventions, legal resources, etc.) (Bess & Stabb, 2009). Therapists working within the transgender community, like many therapists who work with a specialized population, are faced with consideration of the role that cultural competency plays in their treatment (Sue, Zane, Hall, & Berger, 2009). According to WPATH (2012), a mental health professional qualified to work with adults struggling with gender dysphoria should have at minimum a master's degree in a clinical behavioral science, show competency in using the DSM for the purpose of diagnosis, have documentation of supervised training and show competency in providing psychotherapy, exhibit specific knowledge about assessment and treatment of gender dysphoria, and show continuing education in this area.

Cultural competency. Typically, a therapist's competency to practice psychotherapy assumes that he or she has knowledge that certain types of psychotherapeutic treatments for clients can vary in efficiency depending on a client's ethnic and cultural background, and can show skill in treating clients of these various backgrounds (Sue et al., 2009). Culturally competent psychotherapeutic practices then describes interventions that take into account the differing dynamics that occur between cultures, that are informed by knowledge about practices and beliefs concerning that culture, and that meet the needs of the person that might be particular or special to their culture (Whaley & Davis, 2007). In a study by Bess and Stabb (2009) examining experiences in psychotherapy of transgender clients, it was suggested that having "knowledge" of transgender particular culture and special needs meant going beyond information included in textbooks. Being knowledgeable about transgender issues included

“making connections with transgender people, so that they are seen for their humanity rather than their novelty” (Bess & Stabb, 2009, p. 273).

One particular area that requires special attention and competence when working within the transgender community is the importance of confidentiality and managing multiple relationships (Bess & Stabb, 2009, Dworkin, 1992 as cited in Kessler & Waehler, 2005). Due to the typically small numbers and high interconnectivity of this population, as well as the role that local community resources play in providing referrals to therapists who specialize in gender issues, a therapist may see several transgender clients who run within the same social and support groups (Bess & Stabb, 2009). For therapists who themselves are active in the larger GLBT community in addition to working with GLBT clients, it is highly probable that clients will be encountered in social or other professional settings (Morrow, 2000 as cited in Kessler & Waehler, 2005). As high as 95% of therapists who self-identify as gay, lesbian, bisexual, or transgender have reported to have run into their clients outside of the a therapy setting (Morrow, 2000 as cited in Kessler & Waehler, 2005). Morrow (as cited in Kessler & Waehler, 2005) suggests that in managing the dilemma of multiple relationships, therapists who work in the GLBT community tend to make three types of mistakes: (a) therapists may set boundaries that are so rigid that it impairs the therapeutic relationship and or the progression of therapy; (b) therapists might evade boundary setting, or set boundaries that are too loose, that may also negatively impact the therapeutic process; or (c) self-identified GLBT therapists may avoid engaging in GLBT community activities in order to avoid encountering their clients, giving up their own connection to community support which can be damaging to their own mental health.

The client. Generally for clients seeking psychotherapy services from community or not-for-profit counseling centers, treatment satisfaction depends on feeling more capable of

coping with problems, and on whether they would refer others to the services (LaSala, 1997).

This might be especially important for transgender clients who typically find therapists through referrals from friends and other community resources (Bess & Stabb, 2009).

Experiences in psychotherapy. For some transgender clients, mental health issues and distress is impacted by negative feelings or opinions held about the transgender community, as well as preoccupation and apprehension about possible consequences of identifying as transgender (Sanchez & Vilain, 2009). In a study by Angarella (2009), transgender women who had participated in substance abuse treatment were interviewed and reported that their identification as transgender has caused problems early in life and often continue into adulthood, including discrimination and stigmatization in the workplace and from law enforcement.

Bess and Stabb (2009) conducted a study focusing on the experiences of seven transgender individuals in psychotherapy. Study participants reported mostly positive experiences in therapy when experiencing a significant amount of support and empathy within the therapeutic relationship. Participants also reported positive experiences when therapists held similar views about the implications of a diagnosis of GID with respect of pathology (Bess & Stabb, 2009). They also reported positive experiences with therapists who showed flexibility with their own gender identity, as well as those who had experience and proficiency in working with transgender clients (Bess & Stabb, 2009). Characteristics of therapy that made for a positive experience included: (a) openness, knowledge, variability of presented options concerning identity and transition; and (b) work to increase acceptance and definition of the self, and validation and normalization of their experience (Bess & Stabb, 2009). Participants who reported negative experiences in psychotherapy described incidents with therapists who did not specialize in gender issues, and therapists who they felt discounted and rebuffed their gender

issues (Bess & Stabb, 2009). Overall, characteristics of negative experiences in psychotherapy included: (a) lacking a competent therapist, (b) incidents of explicit shows of hostility, and (c) a therapeutic stance of “eliminating pathology rather than facilitating wholeness” (Bess & Stabb, 2009, p. 273).

Rationale for the Proposed Study

Through the history of the transgender community, discrimination, stigmatization, and marginalization has been a barrier to well-being and acceptable treatment socially, politically, and institutionally within the health care system (Ault & Brzuzy, 2009; Heath, 2006; Stryker, 2008). This type of marginalization has been a driving force in the organization of transgender people into a solidified community of individuals pushing for the development and growth of services to others like them. Examples of this has been seen in the early responses of the transgender community to social injustice and persecution by creating services run by, and for, other transgender people (Feinberg, 2006; Stryker, 2008). As the services for the transgender community expanded and support emerged from medical and mental health professionals, well-developed treatment guidelines and informed diagnoses emerged (Stryker, 2008, WPATH, 2001). As awareness and knowledge grew about the impact of discrimination and stigmatization on social and mental health issues of marginalized groups, treatment guidelines and diagnostic consideration began to change, as was in the case of the exclusion of homosexuality in the DSM (Heath, 2006; Stryker, 2008). However, some mental health professionals and advocates within the transgender community suggest that adaptation of new information about transgender individuals has not been adequately addressed in diagnosis and treatment of this population (Ault & Brzuzy, 2009; Bess & Stabb, 2009; Bower, 2001; Megeri & Khoosal, 2007; Winters, 2006). It was therefore the goal of this study to examine the experience of support services (e.g., mental

health services and community resources) from the perspective of a transgender individual. This methodology allows greater insight into the transgender person's perspective, what in their life motivated participation in support services, accounts of how these services were experienced, what a transgender client attributes to success of these services, and what insufficiencies they might have experienced in services provided.

Statement of Research Questions

This study was guided by the following research questions:

1. What types of formal and informal support were utilized?
2. What contributed to negative and or positive experiences of formal and informal support?
3. How have past life experiences contributed to decision making regarding seeking out formal and or informal support?
4. How have past experiences of formal and informal support impacted current utilization of formal and or informal support?

Chapter II: Methods

The aim of this study was to gain an in-depth retrospective account of the journey through experiences with counseling services, and community, social, and familial support in an individual's transition from the female to male gender. The use of a case study research method was chosen to allow for greater information and detailed accounts of the experience of formal and informal support. The results of the study will include a brief description of the participant's background and history, especially as it pertains to the decision to participate in support services, how formal and informal support has been experienced, how the participant subjectively assessed the impact of these services in their life, and what shortcomings they experienced in this area.

Participant Selection

This case study consists of one female-to-male transgender individual. The decision to enlist the participation of a female-to-male transgender person was informed by a review of the literature of studies concerning treatment of gender issues in transgender individuals. The selected participant was required to meet all of the following criteria for consideration of inclusion in this case study: (participation criteria A) identification as a female-to-male transgender person; (participation criteria B) be at least 21 years of age at the time of the first interview; (participation criteria C) have utilized formal and informal support and or resources for at least 3 years as an adult, with involvement in counseling services for least 2 years; (participation criteria D) have begun transition from the female to male gender within the past 10 years but not sooner than 3 years; and (participation criteria E) have knowledge and experience of transgender culture (i.e., a social network that includes other transgender individuals, participation in transgender social events, transgender community activism). These requirements

for participation were set in order to insure that a significant amount of information would be available regarding experiences of formal and informal support within the transgender community.

The first of the requirements entails that the participant must identify as a female-to-male transgender individual. This means that the participant must have been born a biological female who identifies as male (GLAAD, 2007). Next, it was required that the participant be at least 21 years of age at the time of the first interview. The age of majority in California is defined as any person who is 18 years of age or older (Family Code, Sec. 6500-6502). The minimal age of a participant must be at least 21 years old in order to meet the requirement of having intentionally sought and utilized three different community support resources during their period of transition and identification as a transgender person for at least 3 years as an adult. Services sought can include participation in community outreach, transgender peer or support groups, psychiatry, medical support in transition, spiritual supportive services or any other supportive services concerning gender issues. Because not all transgender females decide to undergo complete SRS due to the risks involved in the procedures (WPATH, 2001), it was not required that the participant have undergone or will undergo full SRS in order to participate in this study. It was also required that the participant had begun transitioning within the time frame of the past 10 years, but no shorter than 3 years, in order to be able to provide a significant amount of information and experiences as a self-identified transgender person. For many adult transgender individuals, the first line of support is not always psychotherapy. The above requirements for participation help to ensure that the participant has acquired an adequate knowledge of transgender culture. Meeting the requirement of having knowledge of transgender culture was also identified by the participant's report of having a social network that includes other

transgender persons, participation in transgender community events, social groups and events, and or community/political activism.

Participation in this study posed no more than minimal risk comparable to that encountered in daily life or in routine psychological testing. However, participation in a case study means an in-depth process that involves remembering and reflecting on personal emotions, thoughts, and life events (Berg, 2004; Stake, 1995). Along with descriptions of positive or fruitful experiences of the participant in their involvement with formal and informal support, it is plausible that the participant will also recollect negative or difficult events, thoughts, or emotions that may cause some internal distress for the participant.

Given the possible risks to the participant, although minimal, it was required that the participant be free of significant or disabling anxiety, free of significant or disabling depression, and free of any suicidal ideation for at least 30 days prior to their initial contact with the primary investigator (participation criteria F). Potential candidates that did not meet these requirements were excluded from the study as this would indicate an increased risk for distress during participation.

As all interviews took place at Pepperdine's West Los Angeles Campus, potential participants were required to be able to transport themselves to this location and be available for interviews on Monday and/or Friday during afternoon or early evening hours.

Procedures

The participant was recruited through free online advertisements on Craigslist (Los Angeles Site, posted under Community/Volunteers), and through snowball sampling by individuals known to the researcher who are active in the GLBT community (see Appendix B). This advertisement instructed potential participants who wished to volunteer for participation to

contact the researcher via e-mail. The researcher replied to the potential participant via e-mail in the order in which emails were received (see Appendix C). This email included two documents: (a) a more detailed explanation of the study (see Appendix D), and (b) referrals for clinical counseling and formal support services (see Appendix E). The email also included a list of dates and times for the candidate to choose from so that they can schedule a time to be contacted via telephone by researcher for an Initial Screening Interview (see Appendix F). The initial screening interview assessed inclusion criteria, and allowed the candidate the opportunity to ask the researcher questions about the study. The first candidate met all criteria, and after learning more about the study, agreed to participation, and was scheduled for the first of the three required interviews, to be held at the West Los Angeles Pepperdine Counseling Clinic. At the end of each interview the following interview was then scheduled.

The participant selected for inclusion in the study was required to sign an Informed Consent for Participation form (see Appendix G) at the beginning of the first interview, prior to the start of the study. An incentive was given to the selected participant for their participation in the study in the form of a \$25 Visa gift card; given in person at the end of each face-to-face interview. The participant also received a \$50 Visa gift card for their fulfillment of participation needed for completion of the study (which was not to exceed 3 months following their final in-person interview).

Data Collection

The participant partook in three 90-minute face-to-face, audio recorded semi-structured interviews conducted at the West Los Angeles Pepperdine Counseling Clinic during regular business hours. These interviews were conducted on Fridays, within the time frame of 1 month. Early interviews gathered information about the participant's historical, familial, psychological,

medical, and cultural background. Later interviews were steered specifically towards accounts of experiences of formal and informal support. The researcher took notes and recorded each interview using a digital voice recorder. Recording of interviews were allowed for greater accuracy of originally collected data, contributed to increasing the participant's trust and confidence in the accuracy of the information they provided, and allowed for better demonstrable accountability for information used in the study (Seidman, 1998).

On multiple occasions throughout each interview the researcher checked-in with the participant on the verisimilitude of the data being collected in an attempt to assure that the data is as true to the actual experience of the participant as possible. Also, continued monitoring of the participant's level of distress was done at the beginning and end of each interview through verbal discussion concerning the participant's emotional and cognitive states, and level of distress. Had it become evident to the researcher that the participant experienced significant distress during the study due to their participation as exhibited by emotional and cognitive instability, the participant's participation in the study may have been ended by the request of the researcher for the participant's welfare. The participant also had the ability to withdraw from the study at any time.

Each recorded interview was stored on individual CDs and saved on a flash drive designated for the sole use of the research data, after which it was immediately deleted from the digital recording device. Notes and recorded interviews were identified by date only, in order to help maintain the confidentiality of the information provided by the participant. After each interview the researcher listened to that day's recording and made note of questions not yet addressed on the semi-Structured Interview Guide (Appendix H) to help direct each subsequent interview.

In addition to interview materials, copies of collateral information were made and collected with permission of the participant in order to provide fuller representation of the participant's experiences. Collected collateral information included: sections of personal journals (identified and tagged by the participant), an email exchange between the participant and another transgender individual (from which only information written by the participant was collected as data), and online blogs written by the participant. Copies of identified journal entries were made at the start of the second interview and original journals were returned to the participant immediately after these copies were made. The provided email exchange and blog documents were sent to this researcher via email from the participant and the researcher printed two copies personally, after which the emails consisting of these documents were deleted. One copy of the original copied documents was stored with original interview data. The second copy was designated a working copy, on which all identifying information was blacked out. Hard copies of the collateral documents were also scanned and saved as a PDF document stored on the flash drive designated for original data.

All physical data (i.e., transcriptions, data analysis documents, copies of personal journals/diaries, etc.), and electronic data held on flash drives and CDs were held in a locked personal safe located in the researcher's home, to which only the researcher had access. All electronic data contained on flash drives were password protected, with the password being known only to the researcher. All data material will be kept by the researcher for a duration of 5 years, at which time all material will be destroyed.

Data Analysis

The first step in analyzing the data received from the interviews with the participant was transcription of each interview and the corresponding notes by the researcher using a word

processor. Following the transcription of the recorded interviews and corresponding notes, two copies of the data were made. All copies of the collected original data (i.e., interview transcriptions and collateral data) were printed and filed, as well as saved on a designated flash drive in order to insure its integrity. A working copy of the data was saved and kept on a separate designated research flash drive to be marked and coded for important and reoccurring themes. A second copy of collateral information was also created to be marked and coded for analysis. Pseudonyms and nonspecific descriptions of places of employment, social activities, and services providers were used in these working data copies in order to further protect the anonymity of the participant. All data collected by interview and or collateral materials were de-identified, and all information that may permit identification of the participant (such as names, dates, and memberships in organizations) were changed on the second copy of all data. These measures were taken so as to minimize the possibility of identification of the participant by others who may read the finalized research study document.

The second step in data analysis included an initial read through of the transcribed data in which passages that seemed to provide salient information and important themes were marked with brackets so as to separate the most pertinent information (Seidman, 1998). These marked passages were then labeled according to the theme(s) for which it appeared to speak to (Seidman, 1998; Stake, 1995), helping to organize the narrative and present material in a cohesive manner expressive of the participant's contextual experiences (Seidman, 1998, p. 103). Such information and themes included: gender identity, medical and psychological diagnoses and treatments, formal and informal supportive services, therapeutic relationships, significant familial and social relationships, personal and interpersonal conflicts and resolutions, community, ethnicity, religion, and sexual orientation.

Following labeling, passages were separated from the Microsoft Word document and placed onto an Microsoft Excel sheet assigned for each category (Seidman, 1998). Each passage received a letter and number indicating original placement in the transcript or collateral document (a letter to designate interview transcript, and Arabic number to indicate placement in transcript; e.g., B59) to allow for easier reference to consider passage in original context during the writing process. If a passage fit in multiple categories, it was copied in both categories. When all pertinent data was labeled and separated, the researcher then made a second, more in depth reading in order to further refine salient information, including those that are consistent with themes, those that seemingly connect themes, and those that stood out because of its of seemingly inconsistency (or contradiction) with prominent themes. This more refined, additional labeling included: positive and negative experiences, perceived reactions of others, and personal reactions by the participant to these significant experiences. Interpretation of the selected data consisted of identifying salient connections between coded themes, and drawing conclusions concerning possible implications in the areas of development of supportive services for transgender individuals and needs for further research (Seidman, 1998).

Chapter III: Results

This chapter will outline results of the data collected in the face-to-face interviews with the selected participant. This will included: (a) a brief description of the participant's background and history, (b) specific experiences in both formal and informal support, (c) areas of growth in the available support services as perceived by the participant, and (d) prominent themes.

Participant: "Allen"

"Allen" was the first responder to the researchers Craigslist advertisement. During the Initial Screening interview with the researcher, Allen stated that he learned about the research study through word of mouth, and decided to contact the researcher after reviewing the online advertisement. During this phone screening it was determined that Allen met all criteria required for participation. Allen stated to the researcher that although born genetically female, he has identified as the male gender since childhood, and now at the age of 22 identifies as a female-to-male transgender individual (participation criteria A and B). Allen stated that he has utilized both formal and informal support services for approximately 7 years including individual psychotherapy (since the age of 16), and peer support groups both online and in person since the age of 16 (participation criteria C). Allen recalled first coming out as transgender to high school peers, and reported that although having "a lot of starts and stops" he first began the transition to the male gender (as defined in this study) between the ages of 16 and 17 (participation criteria D). He reported having a social network that consists of other transgender people (participation criteria E). Allen reported having been free from significant or disabling anxiety, depression, and suicidal ideation for at least the past 30 days (participation criteria F). Allen stated that he would be free for the required three 90-minute interviews on Fridays. At the end of the phone

screening Allen asked the researcher about her interest in studying transgender mental health issues, and asked about her academic training. Following a brief discussion of this, Allen was informed that he met criteria for participation, and in collaboration with the researcher set the appointment for the first of the three required interviews.

Brief Background and History

Participant “Allen” is a 22-year-old, bisexual, transgender male (biological female who identifies as male; requirements of age and gender identification) of Irish and German decent, and identified as of the Jewish religion by heritage. Allen was born and raised in the greater Los Angeles area, and is the only child of divorced parents. This section will include information about: (a) Allen’s gender identity, (b) ethnicity, (c) family relationships, (d) personal conflicts and resolutions, and (e) interpersonal conflicts and resolutions.

Gender identity. Allen identified as wanting to be, and perceiving himself as the male gender for as long as he can remember. He has been told by both of his parents that they recall him making statements about a desire to be a boy early in his childhood. However, from Allen’s earliest memories, he recalled a perceived need to keep this information about himself silent.

Allen recalled distinct memories of wanting to play with neighborhood boys as a child, and having a notable dislike for playing with girls. However, Allen typically did not attempt to play the boys games he wished to, describing himself as “not courageous enough to try to play with the boys” (personal communication, September 6, 2013) and therefore played with the girls “like [he] was supposed to” (personal communication, September 6, 2013).

As Allen began to become more aware of his identify as male, he adopted a fantasized figure as the “male embodiment” (personal communication, September 6, 2013) he imagined himself as. He chose a fantasy video game character that, although was identified in the game as

male, seemed somewhat androgynous in his appearance. He thought of this character as something he thought he could become, an “obtainable version of [himself]” (personal communication, September 6, 2013). Allen recalled that during this time he began to experience reoccurring hopes that he would go to bed at night and wake up in the morning as a boy, hoping that God will intervene and change his gender. Allen described a sense of resignation when his secondary sex characteristics began to form (i.e., breasts began to grow) and his menstrual cycle began. He recognized that he indeed was going to develop a female body and that he would not be magically changed into a boy.

Now in adulthood Allen stated that he typically would not label himself as the “quintessential transman” (personal communication, September 6, 2013). Although Allen identified as male, he struggled with a decision to begin hormone therapy (testosterone) and currently does not perceive sex reassignment surgery as a good fit for him. He believed that because it could not fully make him a man (allow him the ability to father children or have a fully functional penis) it felt like an extreme measure to take. In a personal blog he wrote, “for quite a few transgender people its not really about the nibbly bits, its about presentation! The clothes, the styles, the way they’re treated by others. I happen to be one of those people” (Online Blog F, 2012). He went on to describe that the most important part of transition for him is being seen and accepted as male:

But what I really have is ‘sir’ envy. I just want to be treated like a man, to be allowed to participate in things that men do without getting weird looks..I want to be called sir and invited to the table as ‘one of the boys.’ Its stupidly simple.

(Online Blog F, 2012)

Although Allen has disclosed his transgender male identity to significant others (important friends and romantic partners) beginning in high school, in the past few months he has been coming out in a more public manner, including family members and academic faculty. He stated that in trying to convince everyone that his brain is male even if his body is female, he has found himself giving them cues to identify him as such. These included cutting his hair short, lowering his voice, dressing strictly as male, and binding his breasts. He has also noticed that in trying to convince others of his maleness, he has noticed himself conforming to male gender stereotypes in presentation (i.e., getting a buzz cut when he actually prefers to have longer hair).

Allen described himself as now beginning to realize more and more that his gender identity is only a piece of who he is, a resolution that has allowed him to express his gender more clearly in a way that feels comfortable and right for him. He stated that what he does and what he enjoys in life is because of his personality and personal interests, and not because he identifies as male or because he was born into a female body.

Ethnicity. Allen's paternal ethnic heritage is Irish/Catholic, while his maternal ethnic heritage is Russian/Jewish. For Allen, being Jewish was experienced more as an ethnicity than as a religion. He did not feel that his ethnic background had an impact on his identity as transgender, or as male, and did not recognize it as having very strict gender rules. However, he stated that his Jewish background made him an ethnic minority in the schools he attended, which he began to better recognize in middle school. He reported that being an ethnic minority may have helped him to think more critically about people, but it also became "another way [he] was trained to hide" (personal communication, September 27, 2013). When telling people he was Jewish he would often get funny looks from classmates, and on at least one occasion a racial slur

(“dirty Jew”) was directed towards him. This added to his decisions to hide certain things about himself from others in order to avoid negative responses. He stated:

I guess that it all just kind of added up into this experience of, you know, building a box around myself and kind of being like, this is what you all see. And I’m not going to let you see what I actually am because that’s dangerous. (personal communication, September 27, 2013)

Family relationships. Allen’s parents divorced when he was approximately seven years old. His mother took full custody of him and he visited his father on weekends. Allen described this period as mostly a confusing time. He described his parents as being mostly angry each other, and would typically use Allen as a way to make each other mad, including picking him up or dropping him off for visitations late. Allen described not experiencing feelings of fault in regards to his parents’ divorce in the same way that other children may, understanding from early on that the difficulty experienced existed solely between them. However, regardless of this insight, he felt stuck in the middle of the distress in their relationship. Allen believed that the distress he experienced, and the example of relationships that his parent’s set, impacted his ability to build trust in relationships. He recalled that in elementary school it was difficult for him to build friendships, and he worried that people would turn on him.

Allen has been told by both his parents about statements he made in early childhood regarding his desire to be a boy. Although Allen does not know what his parent’s responses were to these statements, he does remember feeling unable and fearful of his parents finding out this secret as he grew. This led him to believe that whatever their response was, it left him feeling silenced early on, which looking back on explained feelings of resentment towards them.

He stated:

It tells me that I was so young when I was doing this that I don't remember it.

And that by the time I was old enough to remember things, I've been, I've been silenced. And, I do hold a lot of resentment towards my parents for that. (personal communication, September 6, 2013)

When Allen eventually disclosed his transgender identity in later adolescence, he stated that his father's reaction was one of disbelief and avoidance. Allen stated that his father continues to have some difficulty accepting his gender identity as male. Allen perceived his mother has having her own philosophy about the importance of fitting in. Allen believed that her silencing of him may have been her way of protecting him from the world that might present a danger to this kind of non-conformity. He recalled telling his mother as an adolescent about his male identity, and she reacted by asking him to compromise. She suggested that he might use a version of his middle name (that was typically male) to refer to himself as, and in high school allowed Allen to cut his hair short, but did not seem to really want to discuss his experience. Allen's mother is currently growing in her acceptance and support of Allen's identification as transgender, as he has again begun to discuss the matter of his actions in publically identifying as male. He stated:

Because I mean, her reasoning was kind of simple, which was, you know, we talked about it 6 years ago and I hoped that it was just a phase and that you would grow out of it. But 6 years is a long time for a phase. So I guess its not a phase and we're just going to have to move forward with it as is. (personal communication, September 13, 2013)

Personal conflicts and resolutions. This section will provide information on specific personal conflicts experienced by Allen at various points in his life, and the ways in which he developed, and or continues to work towards resolution of these conflicts. Personal conflicts reviewed include: (a) coping with gender dysphoria, (b) sexual orientation, (c) coming out and being *outed*, (d) medical interventions, and (e) religion.

Coping with gender dysphoria. Allen reported that indecisiveness about receiving medical intervention has, in the past, created feelings of doubt about the authenticity of his transgender identity. He stated a recognizable difference in his experience of dysphoria with his female body, and described it as not as painful than what he has noticed it can be for other transmen. He believed he may be able to obtain some satisfaction with his physical appearance if, in addition to his male presentation in regards to dress, he is able to achieve a more masculine physic through weight loss and muscle gain. Allen stated that engaging in bodybuilding was one way in which he was able to cope with the body dysphoria he experienced in adolescence.

Allen also became very involved and focused on non-gendered activities, such as academics and a robotics team. This seemed to help him to keep his gender struggles away from the forefront of his thoughts. He stated, “I think that part of my coping mechanism, and I’m going to be honest, is that I just kind of forgot about it” (personal communication, September 6, 2013).

Sexual orientation. Allen identifies as a bisexual male. He has experienced attraction and romantic feelings for females, but has solely had romantic relationships with men. As bisexual, Allen expressed experiencing an added layer of exclusion within the GLBT community. Especially in high school, Allen experienced others as pressuring him to pick a sexual orientation (i.e., gay/lesbian or heterosexual). In addition, he expressed that having sexual

attraction to men created some conflict around his gender identity, especially in regards to the more feminine role he typically takes on in these relationships. Although gender identity and sexual orientation is viewed as separate, Allen feels that for him this may not be completely true. In a blog he wrote, “Being sexually interested in a man grounds me to my born gender. I still can’t decide if this is a betrayal of the person I was born to be” (Online Blog F, 2012). During the study interviews he expressed a type of fluidity of his gendered behavior in romantic relationships; experiencing greater ease in expressing a more feminine role with men, and a desire to be more masculine when attracted to females. In reference to the term *genderqueer*, Allen spoke to this increased fluidity of his self-perception, and in a personal blog he wrote:

After all, my self-names have changed pretty consistently as I’ve grown, as well as my ideas about intimacy, and family. It allows me to safely navigate (what I see as) a contradiction between my fantasized identity and my real sexuality.

(Online Blog F, 2012)

Coming out and being outed. Allen reported experiencing fear around coming out as transgender in regards to concerns about his personal safety, and worries about potential negative reactions or rejections from others. Learning about violence against transpeople reinforced some of Allen’s fear about potential negative consequences in disclosing his transgender identity. He stated:

If somebody said that to me, which is, like, you know, if you want to be represented, you know, you better show up and speak up. I’d be like hell no.

That it is, that is dangerous to my health, to my future. (personal communication, September 27, 2013)

Here Allen is also referring to fear of discrimination against transgender individuals, especially in regards to his educational and professional career goals. This was part of the reason why Allen did not participate in GLBT activities and groups during his college years. He believed that doing this would give many people access to information about his transgender identity, creating the potential to be inadvertently outed in front of people he wasn't sure he wanted to know about his transgender identity. He stated, "I can't assume that all my professors are going to be open to this, and I need my professors to be on my side to get me through to the next level" (personal communication, September 27, 2013).

Over the recent months before the interview, Allen had decided to come out as transgender in a public way, no longer reserving information about his identity to friends or significant others. Allen is finishing his Bachelor of Arts degree, and at the time of the study was in the process of applying to graduate schools to pursue a medical degree. Allen perceived his time in college as a period in which he was learning more about himself and developed a greater sense of self-acceptance. He stated, "And so now its time for me to get into a community where they accept me. And I'm comfortable and not changing myself to make everybody else comfortable" (personal communication, September 27, 2013).

Medical interventions. Allen expressed feelings of conflict about receiving medical interventions for gender transition, including hormone therapy (testosterone) and sex reassignment surgery. Although these are the typical interventions, in addition to psychotherapy, for the treatment of Gender Dysphoria, he currently does not perceive these interventions as being the right fit for him at this time. He stated:

Uh, and I think that that's something that the larger transcommunity is starting to talk to each other about. Is that there was always this assumption that to really be

trans you have to get surgery because that's what's legally on the books. (personal communication, September 27, 2013)

His current intentions are to try to alter his body as much as he can through physical exercise (i.e., weight loss and muscle increase) to try to achieve a body type that he feels more comfortable with. After this he then intends to reevaluate his experience of body dysphoria, and reconsider hormone therapy. He stated, "I want to be decisive, and lets be real, hormones aren't going to magically change me from a woman into a man" (personal communication, September 13, 2013). There is similar conflict experienced by Allen in regards to sex reassignment surgery. Allen's knowledge of the limitations of surgery, such as the functionality of the created penis and the potential harmful risks of surgery, that make this seem like a less appealing option, and a generally scary concept. He stated:

And that, you know, I've always had kind of a, surgery grates against my mind. Like I don't really want to get phalloplasty because, you know, its never going to be really functional. Its going to be, its kind of. You know I know that a lot of work goes into it, but it still feels like arts and crafts, kind of. (personal communication, September 27, 2013)

In a personal blog he discusses this issue further, and wrote:

In my mind, it really boils down to this; surgery is scary and irreversible. Far from 'coming out' to your friends by just saying 'hey I'm gay', what's asked for transgender people is to put their bodies UNDER THE KNIFE in order to declare their identity. (Online Blog F, 2012)

A medical intervention that Allen wished he had the opportunity to utilize when able is puberty blockers, a hormone treatment that delays the advancement of puberty during a child's

adolescence, thereby suspending the development of secondary gender characteristics (WPATH, 2012). Allen felt that if he had been able to avoid developing the typical female facial and body features, he might have been a happier adult, making it unnecessary to make the same compromises with his appearance and gender presentation. He went on to state, “And at some point, you know, for some people, they never really pass. You know, they’ll always stand out a little bit” (personal communication, September 27, 2013).

Religion. Allen’s father was Catholic by heritage, but was non-practicing, while his mother’s family was Jewish by heritage, and also non-practicing. As previously stated, his mother’s family identified their Jewish heritage as more of an ethnicity than religion. Growing up Allen’s mother explored various religions, but Allen stated that the issues of faith and religion were not typically talked about on either side of his family. Allen himself identifies as Christian, being initially exposed to the religion informally when over-hearing teachers mention engaging in a family activity after or before church. He stated, “You know, it seems like God is a positive influence in their lives” (personal communication, September 27, 2013).

Allen’s own interest in religion and God was driven by a search for a reason for his gender experience. For Allen, religion became a form of coping; “You know, trying to steadfastly believe that I was made this way for a reason. And not just a mistake of biology” (personal communication, September 27, 2013). Through his involvement in Christianity Allen felt able to discover a “silver lining ” finding good in a bad situation. He began to see his gender experience as allowing him to develop a deeper understanding of the female experience, and an appreciation for the experience of discrimination and sexism, which he believed will serve him well in a health profession, in which he hopes to work with woman in under-resourced countries. He also believed being transgender gives him the opportunity and motivation to be an advocate

for others with similar experience. Lastly, Allen believed that his involvement in Christianity has helped to reduce his feelings of anger about the struggles he experienced around his gender identity and the limitations of medical treatments. He stated, “I think that having faith just kind of prevented me from getting so angry that I’d been born wrong and that my only way of fixing myself was this sort of, you know, glue and macaroni kind of solution” (personal communication, September 27, 2013).

Allen described experiencing acceptance within the Christian community, and feels he faces less rigidity and stereotyping of what it means to be transgender. He gives them the language and sets the definition of what it means for him to be a transman, and therefore does not face the scrutiny that at times occurs within the transgender community. He stated:

You know, nobody in the trans...in the Christian community is going to say, yea but you’re not really trans enough. You know, you’re not acting enough like a guy for me to take you seriously as a guy, you know, they’re kind of like, oh okay. If that is what being transgender means, then cool. (personal communication, September 27, 2013).

Allen stated being *closeted* about being Christian, and experiences hesitation in disclosing his religious identification because of concerns about how others might react. Allen stated recognition and appreciation that some people have been hurt by faith due to teachings and actions carried out in the name of various religions. He discussed that when *coming out* as Christian he feels the need to explain his beliefs in order to make others comfortable, for example explicitly stating, “...by the way, I don’t hate gays, and I don’t think that people of other religions should be put to death, and I’m not going to try to convert all of my friends by shoving this down your throats” (personal communication, September 27, 2013).

Interpersonal conflicts and resolutions. This section will provide information on specific interpersonal conflicts experienced by Allen at various points in his life, and the ways in which he developed, and or continues to work towards resolution of these conflicts including: (a) social relationships, and (b) romantic partners.

Social relationships. In early childhood Allen experienced difficulty making friends, due to feelings of distrust of others and caution in engaging in activities with male children. As he grew into adolescence and did not fit into the typical female adolescent presentation, Allen began to experience social pressure from peers towards feminine conformity. He experienced harassment at school from particular students who would make comments about not looking like or dressing “like a girl.” During middle school Allen also began to experience his male friends as beginning to look at him and treat him in a more sexualized way, creating him into “somebody to be impressed” (personal communication, September 6, 2013), and creating new expectations of feminine conformity. Eventually Allen gave in and presented as more feminine although this created intense feelings of discomfort.

Allen expressed a fear throughout his adolescence of being alone and of never being loved. He often felt like he stood apart from people, and at times felt like a “freak.” In order to create and maintain close relationships with friends and romantic partners he largely hid his identity as a transgender male. Although Allen experienced rejection and avoidance of his gender identity in his parental relationships early in his life, more recently he has begun to experience more acceptance and support from friends, romantic partners, and parents in regards to his trans identity. In a more recent event of disclosing his identity as a transman to close friends he experienced complete acceptance. However, although this kind of unconditional acceptance was a positive experience, he did not feel that he received acknowledgement and

appreciation of the importance of this disclosure, highlighting the importance of this piece of his coming out experiences. He stated:

It's the, you know, we don't care, we love you for who you are. But at the same time we haven't grown up in a utopia. I didn't grow up in a utopia. So in this kind of overlooking my identity, my, the importance of the experience. (personal communication, September 13, 2013)

Allen is developing his own patience with significant people in his life, especially people who have known him strictly as female, to allow them time to go through their own process of learning to see him as male (i.e., using male pronouns and calling him a different name.) He stated that flexibility and being taken serious by others is helpful and needed when going through the process of transition, aligning his outside presentation with his identified gender. Allen gave the example of flexibility even with picking a new name:

The freedom of movement with that. Of, you know, being able to say I'm trans but I don't know what my name is. Or I'm trans and I picked a name, but its really not working for me, so you could you all like, try this new one on? (personal communication, September 27, 2013)

Allen stated that most important is the "recognition and the effort" from others to continue to develop their understanding of him and to maintain a relationship with him.

Romantic partners. Allen began dating males in high school and expressed having made compromises throughout most of his romantic relationships. Allen has dated mostly heterosexual males who were attracted to him as female, and although he did not fully accepted this kind of attraction to him, he chose to not acknowledge it in order to build romantic relationships. "I just sort of went with it because I didn't see how it could be any different"

(personal communication, September 6, 2013). During high school it did not feel safe for Allen to come out as transgender, so “as long as [he] was hiding it” he felt he might as well allow himself to create intimate bonds with people. When Allen experienced attraction to heterosexual females it became a reoccurring theme that these relationships felt essentially unattainable because Allen was not biologically male. He stated, “I was not courageous enough to say at that point, but I am a guy. You know. I’ll come find you after the sex change” (personal communication, September 6, 2013).

When Allen did begin to disclose his identity as a transman with his romantic partners, he mostly experienced his gender identity as unappreciated. He explained:

That I would get into these relationships with straight men and they would all be like, well I understand that you feel like a guy on the inside. And I respect that, but as long as you have a vagina, I’m fine. (personal communication, September 6, 2013)

Allen found himself making compromises in order to maintain these romantic relationships, including being introduced to his partners’ family members as female, or being the “female date” when they go out. In his attempts to achieve a desired feeling of connection and love from others, Allen experienced emotional conflict when becoming involved in intimate relationships that did not recognize or appreciate his identity as male. In reference to unhappiness experienced in a past relationship, Allen wrote in personal blog:

Its also sort of my fault, because, well, I allowed it to happen. Its always my choice to acknowledge their unilateral sexuality, leave the relationship and continue untethered on my journey of self-actualization. But lets be real, lonely is a terrible option. (Online Blog F, 2012)

In his current relationship Allen is experiencing greater recognition and effort by his partner to understand Allen's identity as a transman. Although Allen spoke little about his current relationship, he did state that he, and his partner's family, are trying to be supportive of his gender identity.

Experiences of Formal and Informal Support

Allen has utilized both formal and informal support services throughout his lifetime. Formal support utilized by Allen included: Gay Straight Alliance (GSA) club in high school, meeting with his high school advisor, and formal psychotherapy with two different clinicians. Informal support utilized by Allen included primarily Internet resources including: online support groups, and transgender blogs and websites. This section will review Allen's experiences with both formal and informal support.

Formal support. This section will describe Allen's experience with forms of formal support, and specifically the four individuals with whom he interacted. These include: (a) "Dr. Adams," the faculty advisor to Allen's high school Gay Straight Alliance club; (b) "Ms. Bell," Allen's high school academic advisor; (c) "Dr. Cooper," a psychiatrist covered by Allen's insurance provider; and (d) "Danielle," a marriage and family therapist. Allen disclosed his transgender identity to each of these individuals, and feels that in some ways these individuals were fundamentally unhelpful due to a general lack of attention and response.

High school GSA and "Dr. Adams." In high school Allen decided to attend the newly formed GSA in search of peer support around his developing gender identity and expression. During the introductory portion of the meeting Allen disclosed that he did not identify as female, and asked that students use the pronouns *Ze* or *Zer* when addressing him. The group of students themselves, except one individual who contacted Allen around this topic at a later time, seemed

to ignore his disclosure and did not make mention of it again. Dr. Adams, the faculty advisor for this group, was present during this meeting. Allen recalled that after the meeting Dr. Adams commented to him that she believe their high school was “too small” for him. Dr. Adams never addressed Allen’s gender identity directly, and no other conversation or exchange was had between them.

He stated:

She never asked me if I had talked to my parents about this. She didn’t ask me if I was receiving counseling outside of school. She didn’t offer me any resources.

Uh, she, she sort of just consumed the information, made a quick judgment, and never touched it again (personal communication, September 13, 2013)

Allen interpreted this comment as meaning that he would not be able to address this issue while in high school, and that neither she, nor the school, was equipped to help him. The avoidance that Allen experienced felt like being ignored, which he stated is “a different way of being silenced” (personal communication, September 13, 2013). He stated:

It was like being shut up by omission. I saw that my actions were not having any effect. So why would I keep taking those actions. So I didn’t want to put myself out there any more than I already had. (personal communication, September 13, 2013)

Allen perceived Dr. Adams as a major authority figure in the school, and so experiencing her as not providing support to him when he disclosed his gender identity made him believe that he would also not have the support of other faculty. Allen believed that this experience stifled his movement forward in the coming out process, leaving him not feeling safe to come out to other students or faculty. He explained:

When the counselor, when [Adams] decided not to be, um, be helpful then it certainly stifled my movement forward because I kind of gauged that other people of authority would react the same way she did. And that the best I could expect from other students was apathy. And the worst I could expect from students was, uh, overt violence. (personal communication, September 13, 2013)

“Ms. Bell.” Ms. Bell was Allen’s high school academic advisor, who Allen felt close too, and who had a lot of knowledge about Allen’s relationship with his then boyfriend “Todd,” whom she also advised when he was a student at the same high school. Allen disclosed his transgender identity to Ms. Bell in a conversation about the ending of this relationship because of Allen’s identification as a transman. Allen felt “blue screened” by Ms. Bell, who went on to discuss the breakup in the context of a male and female relationship, but never made a mention during this conversation about Allen’s identity disclosure. He stated, “You know, she could not handle the information I had just given her. She basically pretended like she hadn’t heard that part” (personal communication, September 13, 2013). Allen interpreted this response as likely occurring because of Ms. Bell’s knowledge of him as female; “Um, that my actual identity was so out of sync with how she knew me, or thought she knew me, that she simply couldn’t process it. Like it made no sense so she rejected it” (personal communication, September 13, 2013). Allen’s experience and perception of Ms. Bell was as someone who in the past had been very supportive, and therefore he felt that this relationship could not be ended for what he perceived as an inability to process or handle the presented information. At this time Allen was close to graduation, and because of this felt the better reaction was for him to not mention it again.

“Dr. Cooper.” At 18 years old Allen began to utilize his medical insurance to see his current psychiatrist, Dr. Cooper; initially to address depressive symptoms and relationship distress. Allen was also looking to the knowledge of Dr. Cooper to help him address his transgender identity. However, when disclosing his transgender identity, Allen reported that Dr. Cooper did not address this issue, and instead continued to focus therapy on the relationship distress he was experiencing in the perspective of a male dating a female. Allen expected Dr. Cooper to inquire about the development of his gender identity, or his gender identity in relation to the development of the relationship. Recently when asking Dr. Cooper directly about why they have never addressed his transgender identity, Dr. Cooper responded that because it was brought up when discussing relationship issues, he felt it was more important to address the relationship first. He also informed Allen that at the time the particular insurance company that was covering his mental health services did not cover payment for treatment of gender identity disorder. Allen stated:

It was sort of like a combination of impotence to really give me treatment and a focus on this other issues that led to what felt like a complete ignorance of this kind of important issue that I brought up. (personal communication, September 13, 2013)

When asked about a response he would have like from Dr. Cooper, he expressed wanting to have experienced some kind of acknowledgement of the importance of the issue of his transgender identity, as well as for him to have provided some information about potential or available options for treatment, or helpful resources. Allen expressed that he would have also appreciated an explanation of why the psychiatrist was unable to address the issue of Allen’s transgender identity as a primary concern due to insurance coverage limitations. Generally,

Allen has experienced Dr. Cooper as having limited knowledge about transgender issues, and has in subsequent sessions provided Dr. Cooper with information about terms and general transgender community concerns.

“Danielle.” Allen first met with his mother’s therapist, Danielle, for a brief period at the age of 16, also to address ongoing relationship concerns. During their first session together Allen disclosed his transgender identity. Danielle responded to Allen by exploring why he felt as if he wanted to be male. Allen responded in a way that made sense to him at that time and discussed wanting to feel strong in reference to his feelings of powerlessness. Danielle laughed and stated that it seemed Allen “wanted to spend more time at the gym” (personal communication, September 13, 2013), perceiving his statements to be in reference to physical strength and that perhaps Allen thought that testosterone was the best way to accomplish this. This response left Allen feeling that his identity was being depreciated. He stated, “It certainly put me on the defensive, I think. It made me very cautious about answering any more questions, of making myself vulnerable to the same manner of skepticism again” (personal communication, September 13, 2013).

In following sessions Danielle brought in information to Allen; specifically an in-depth article about a female identified male child, and asked Allen to read it to help discussion of his own experience. Although Allen appreciated this effort to understand his experience, or to help Allen develop in his own understanding of his gender identity, he felt that although able to draw parallels between his own experience and the child in the article, the information did not feel completely relevant. Allen felt that this ultimately hurt the therapeutic relationship. He stated:

Um, yea, so, she tried. But there was definitely a lack of sensitivity, and a lack of relevance. And it, I think that my relationship with her in talking about this, kind

of fell apart because I felt like she didn't really know what she was talking about.

(personal communication, September 13, 2013)

Allen visited Danielle again years later, jointly with her mother in order to discuss a conflict they were attempting to resolve. The conversation about Allen's transgender identity was again discussed. Allen sensed some surprise from Danielle about his continued male identification. Allen asked that Danielle refer to him using male pronouns, and although she tried for a few sentences, she ultimately stated a need to continue to use female pronouns. He stated:

And she was like, so you want me to call you 'he' now. And like tried for like two or three sentences and then was like, I just can't do it. I can't, you know, get it straight in my brain. I have to call you 'she.' (personal communication, September 13, 2013)

Allen expressed forgiveness of her inability to refer to him as male because he believed that it was not an automatic switch that was easy for everybody to do.

Informal support. This section will describe Allen's experience with forms of informal support. Allen explained that he did not attend formal or informal support groups, or meet-up groups that provided face-to-face contact within the transgender community for various reasons. These included the possibility of being outed as transgender accidentally by group members in front of individuals whom he did not wish to have the information, and to avoid potential scrutiny from other transgender people. Allen discussed hearing stories through word of mouth, and in his own interaction in online groups, of the discrimination and gender stereotyping that occurs within the community. This included how to be transgender "the right way" and the right and wrong ways to be male.

Informal support that Allen did utilize was the use of internet resources, including online support groups, blogs, and websites providing personal stories, information, and tips aimed towards the female-to-male transgender community. For Allen, accessing information during his transgender development through online communities became a means of obtaining support anonymously, which allowed him to avoid potential direct scrutiny from other transmen. This section will review Allen's use of informal support in regards to: (a) positive experiences, (b) negative experiences, and (c) experiences in the larger GLBT community.

Positive experiences. Allen experienced the Internet resources as important and useful way for adults and children who might be experiencing fear or confusion around their gender experience to access information in a safe way. He stated: "So, so what I did find were little glimmers of hope over the internet. And it was kind of like my secret salvation" (personal communication, September 6, 2013). His use of the Internet resources became a way for Allen to obtain support from others throughout his gender identity development. In a blog he wrote: "I am discovering this community of people who are, without addressing me, telling me that my experiences are real and that transition may really be the answer to a happy life..." (Online Blog F, 2012).

Allen particularly was drawn to "online transgender channels" that post videos of different transmen speaking about various topics, including policies around name change, state marriages, relationships, dress techniques to increase one's ability to *pass* as male, and medical and psychological treatments. Allen stated that these channels acted as a support group for him, allowing him to observe, hear, and learn about the experiences of other transmen. Allen expressed that reading transmen's personal stories and talking to other transmen online helped him to recognize the flexibility that can be had in developing his sense of self that integrated

both his male gender identity and his remaining feminine side.

Allen recalled one particular video that was helpful for him to increase this kind of flexibility. The video was made by an FTM who had received hormone treatment for several years and decided that, although he continued to identify as a transman, he did not wish to remain on testosterone. The multiple videos depicted his physical changes while cycling off of testosterone, and discussed his continued feelings of maleness and self-acceptance. This aided Allen in finding resolution with feelings of fear that he was not, or could not, be “male enough” to be considered transgender or fully male. Allen expressed that watching this video helped to relieve pressure to participate in hormone therapy, and do make treatment decisions that were right for him. He stated, “And, uh, the message of the video was, no matter what you decide to do, um, there is no one right way to be trans, and you are trans enough. If you say you’re trans you are trans” (personal communication, September 27, 2013).

In addition to his own support, Allen was able to find support for his current partner through a transgender channel for individuals who are dating transgender people. Allen found a story about a male who was also dating an FTM. The story noted this person’s emotional response to his partner’s transition, which Allen reported was helpful in aiding his boyfriend to feel validated and able to explore his own experience in the relationship with Allen.

Negative experiences. Allen’s negative experiences of informal support focused primarily on unsolicited advice given within these online communities. Allen’s first experience of this was in a personal interaction with a high school classmate. This person, whom Allen believed was trying to be helpful, had given him advice on what he should say to his psychiatrist in order to receive a GID diagnosis and obtain medical treatment. This person received this information through word of mouth from a FTM transwoman, and advised him to tell this

information even if this was not true to Allen's own experience. In reference to this experience Allen stated:

And I guess it was in his head that I was so sure about what I wanted to do next that it was in my best interest to cross every line to convince them that I was the real deal and get what I wanted. Um, and I don't think that that's appropriate either. (personal communication, September 27, 2013)

Allen also experienced unsolicited advice on the best way to be transgender. Allen has witnessed various stereotyping that occurs within the transgender community in regards to an individual's presentation as their identified gender, which he felt can be very rigid. Allen recalled a particular person who was replying to online comments made by others in support of a transman's decision to end hormone treatment. This person consistently commented on supportive posts that, although it was okay to be themselves and choose to not follow through with medical treatment, it also meant that they were not really transgender. Allen stated: "Cause I feel like that's a huge concern in the trans community. That in order to be accepted as your target gender you have to completely conform to every stereotype there is about your target gender" (personal communication, September 27, 2013). Allen believes that this additional pressure to meet standards and expectations set within the community can cause additional personal distress.

The GLBT community. Allen stated that although the larger GLBT community seems to attempt to include transgender people, "...it was pretty clear that the 'T' was silent. That really the LGBT movement was about gays and lesbians" (personal communication, September 27, 2013). Allen gave the example of the legal movement for same-sex marriage which he stated focused on natural born gays and lesbians, but did not

discuss the difficulties experienced by transgender couples. He also discussed the repeal of the Don't Ask Don't Tell policy, that allowed gay and lesbian woman to serve openly in the military. In an article he read on a GLBT website, the article discussed lesbians joining the military following the repeal. Allen expressed concerns that neither the article, nor the larger public movement, addressed the continued struggle of being transgender and serving in the military or wanting to serve in the military. He stated, "Uh, cause that would be saying, you know, if you're really my ally, if you're really my sister in arms then you would be saying, I'm not enlisting until my transgender brothers and sisters can enlist too" (personal communication, September 27, 2013).

Allen expressed that the lack of attention to transgender issues within the larger GLBT community created a perception that if he attended GLBT support groups or activities at his university, being transgender would make him a minority among this group. In addition to avoiding this minority status, he experienced worry of being exposed to scrutiny regarding his presentation and labeled by others with greater group authority as something other than a transman. He explained:

Um, but I always kind of feared, I guess, and this might have been the reason I didn't go to LGBT functions, that I would go into this room and people would start saying, well, no you're not actually a transman, you're genderqueer. You know, do that sort of Q and A and label me for me. Which is something that happens.

(personal communication, September 27, 2013)

Perceived Areas of Growth for Support Services

This section reviews Allen's perceived areas of growth and suggestions for improvement for formal and informal support services.

Formal support services. Allen believed that formal information disbursement for younger children is an important piece in normalizing the experience of a transgender child, and to allow for greater openness in reaching out for support by engaging in open conversations with adults who might be able to help. Allen thought this may be most possible through the use of school sex education seminars that could include common and basic information about experiencing gender dysphoria when discussing issues of puberty. He stated, “That there’s so much space within schools for things to go wrong, and there’s so much space for schools to be a vehicle to deliver information that kids didn’t even know existed” (personal communication, September 27, 2013). Allen believed that this kind of formal information might also be available for parents involved in parenting classes, allowing for easier recognition of signs of potential transgender issues in their children, and options on how they might approach discussion of these issues. He suggested:

Like, you know, if if your kid, you know, seems to be behaving in this way or saying these things don’t ignore it. Its not a phase. Please, you know, call this number. You know, take your kid to a counselor, or a doctor, you know.

(personal communication, September 27, 2013)

Informal support services. In regards to informal support, Allen believed that within GLBT groups (formal or informal), there should be an increased sense of inclusion for the transgender community in regards to discussion of transgender related issues, and flexibility for self-labeling and self-discovering. He stated that he would like a greater sense of inclusion for transgender people in the GLBT rights movement, and suggested that this would seem to be best started with trainings for leaders within these larger communities or school based programs. Lastly, he believed there is a necessity for “transmaterial” to be more easily available and

accessible for the heterosexual and cisgender community in order to allow for increased information understanding.

Prominent Themes

Four prominent themes emerged from the results of this study. These included: (a) avoidance and invalidation experienced with both informal and formal support, (b) rigid boundaries regarding acceptable gender identity expression, (c) using silence and compromise in reaction to unhelpful experiences of formal and informal support, and (d) intragroup dynamics of exclusion.

Avoidance and invalidation. The first prominent theme shown in the results of Allen's interview was the experience of avoidance and invalidation in both formal support and within significant interpersonal relationships. Avoidance was typically experienced in the form of lack of acknowledgement by others of Allen's stated male gender and or transgender identity, resulting in feelings of invalidation of the significance of his identity and his disclosure in search of support. This occurred early in Allen's childhood and adolescence within his parental relationships, who perceived his gender identity as a phase, and asking him to compromise his gender expression. In regards to his father's reaction he stated:

And so basically his whole thing was disbelief. He thought it was a phase. He thought it was just a stupid, little kid, thing that I would grow out of. And so I guess he just ignored it. And because he was ignoring me and I realized, that, you know, with my little kid brain that that saying things wasn't getting me the response that I'm looking for, I just stopped. I stopped saying anything. And so by the time I was able to form memories I was thoroughly in the closet. (personal communication, September 6, 2013)

In regards to his mother, Allen stated:

So I feel like its very likely that she silenced me and told me to just, you know, to stop saying that I was a boy and accept that I was not a boy and accept that I was a girl so that I would fit in. So that I, you know, would, so that I would be a normal kid. Cause that was her way of protecting me. Cause I guess she thought I needed protection from the world. And the best way of doing that was to be cis-heteronormative basically. (personal communication, September 6, 2013)

Invalidation was also experienced in requests for compromise around his gender expression. He recalled an event, during which his mother seemed to exhibit some willingness to allow him to engage in some cross-gender behavior, but neglected the significance of his experience of identifying as male, and avoided further discussion of the issue.

Which was, well can't you just tell people that your name was John. Which was, you know, sort of a, you know, go ahead and experiment sort of thing. But it, she didn't really want to talk about, you know, why do you feel this way? What do you see as your plan for the future. (personal communication, September 6, 2013)

In addition to his parental relationships, Allen expressed a lack of appreciation of his gender identity within important interpersonal relationships. Allen described his first disclosure of his transgender identity to a romantic partner:

And I believe that when and I'd come out to him as transgender, like a year prior, you know, I started really admitting to myself, and then to my boyfriend that this was an issue. That this is something that I wanted to tackle. Um. And the year prior, when I was like, uh sixteen turning seventeen uh, he pretty much shot me

down. He would say things like, you are not really a man. You're just a girl who wants to be strong. (personal communication, September 6, 2013)

Allen went on to explain his partner's response in a later interview, stating:

Uh, after one year I came out to him as transgender. He didn't handle it well, at all, and then he sort of like vacillatingly handled it or didn't, or you know, responded positively or responded negatively depending on the day. Uh, which was extremely confusing, uh, in retrospect, um, that I was kind of being led on this winding path. (personal communication, September 13, 2013)

When disclosing his transgender identity to school faculty or helping professionals, Allen experienced both a lack of acknowledgement and invalidation of his disclosure. When describing his disclosure to his high school advisor he stated:

And she just kept rambling on about, well I agree that its best that you guys break up because you have a lot more potential and choices in schools than him and you should not, you know, let him hold you back. Blah blah, blah blah, blah blah. You know, boy problems. You know, boy problems in the context of a girl. (personal communication, September 13, 2013)

In reflecting on his reactions to a lack of acknowledgement of his disclosure by the faculty supervisor of his high school GSA, Allen recalled feeling unsupported and with a continued need to keep his identity silent. He stated:

Well, I mean "Adams" was the first, cause I think she was the vice principal at that time too. So, she was kind of the figure head of support from the faculty. And I knew that I couldn't have come out in high school and be myself in high school if I didn't have support of the faculty. And so I basically like, tested it out

on her. And I realized, you know then, that, uh, I wouldn't really have support.

(personal communication, September 13, 2013)

When recalling the experience with his therapist (Danielle) in regards to her reaction of laughter when discussing his desire to be male, Allen stated:

But as soon as she laughed at me, you know, as soon as she trivialized my experience and trivialized my conclusions about myself, and basically said, you know, all of this maleness that you feel, that's just a manifestation of you wanting to be stronger. (personal communication, September 13, 2013)

He also experienced his psychiatrist as not acknowledging the importance of his disclosure. Although his reason for not addressing Allen's transgender identity was explained to Allen later in therapy, Allen indicated that he would have liked immediate acknowledgement of his stated identity.

And it would've really put a lot of my, you know, worries to rest if those things had been stated explicitly of, we're not going to talk about about this right now because I can't offer you hormone therapy and I think that once we get your relationship problems sort of sorted out then we can approach this with better clarity. That's what I would have wanted to hear. Um, but I didn't hear that. I just heard that sort of blip, and now we're going to skip on to something else. (personal communication, September 13, 2013)

In addition to lacking an experience of acknowledgment or validation of his transgender identity from both his psychiatrist and therapist, he also experienced them as lacking in knowledge of transgender issues. He stated:

Yea, to my therapist. I was teaching her, you know, what like cisgender meant. And I actually had that same conversation with with my uh psychiatrist. He doesn't know what cisgender means either, until I told him. Which is forgivable on some level because it's so niche, and on the other side its not because they're professionals. It's their job to know this stuff. (personal communication, September 13, 2013)

Allen also experienced a form of avoidance and invalidation even when experiencing acceptance of his gender identity. This was experienced as a lack of appreciation of the difficulty he faced because of his transgender identification. In regards to acceptance by friends following a disclosure of identifying as transgender, Allen stated:

Because in, in the utopic world where everybody gets to identify as themselves and its not a big deal, then my gender identity wouldn't be a big deal. But because its persecuted, it is a big deal. So when they didn't really ask me any more questions, or kind of like express...I only realized this later. Like something had always bothered me about their response but I only realized later that it was a lack of sympathy for what I had gone through. (personal communication, September 13, 2013)

He went on to explain:

Like, its like they didn't realize that the implication of me being transgender meant that I'd gone through years of having to hide and feeling like I didn't fit in my skin, or didn't fit in with other people. And so there wasn't that that recognition of the struggle. I guess. So I was very appreciative that, you know,

that they love me and they're still my friends. (personal communication, September 13, 2013)

In regards to his experience of the larger GLBT community, Allen perceived a negligence to fully address transgender issues with consideration to the movement for rights and equality, thereby further demonstrating a theme of avoidance and invalidation of his transgender experience. When recalling his experience of participation in his high school GSA, Allen stated:

The the response from the other students wasn't exactly heartening either because there wasn't a response. I mean, nobody really talked to me about it, or asked any questions. It was just sort of a, oh, that's how you feel. Hmm. Moving on. Its like but, but wait, this is important. This is significant. (personal communication, September 13, 2013)

When reflecting on GLBT activities and activism around same-sex marriage that took place on his campus, Allen recalled feeling a significant gap in attention to the transgender community. He recalled:

Um, but, because that was like, the the key thing, you know, nobody was really paying any attention to like, you know, transmen who wanted to marry men, transwomen who wanted to marry women. Like it was pretty much the natural born gays and natural born lesbians were getting all of the attention. Um, and so in that way I felt like even if I did go to the LGBT community I would be very much a minority. (personal communication, September 27, 2013)

Rigid boundaries of gender expression. Allen experienced rigidity in regards to what it meant to be transgender and what it meant to be male in the FTM community. He found himself

perceiving a need to fit into male gender norms and when difficult to do so, he experienced doubt about this male gender identity. He stated:

And so uh, I was afraid of, uh, kind of opening myself up to that kind of scrutiny. Or to being pressured into being something that I wasn't, in either direction. You know for people to say you're not trans enough. You should just stop trying to be trans, you know. You're a girl, just get over it. Or people saying, you know, if you want to be, you know, more of a trans guy you have to do this and this and this... (personal communication, September 27, 2013)

When recalling his current movements towards greater self-acceptance, he explained how attending to the actual range of gender presentation within the transgender community was helpful. He stated:

And it started making me feel a little less insecure about my kind of, remaining feminine side. Like the, those aspects of me that were, that still pulled me towards, well maybe you are actually a girl. Um. And so, speaking to other transpeople kind of like helped me with that. (personal communication, September 6, 2013)

Allen reported that beyond support from other transgender people, he also began to find greater self-acceptance through interacting with others who also did not seem to fit into gender norms. This was demonstrated in his description of a female friend:

In some ways she's more masculine than me. Uh, which actually, once I had these conversations with her where she's like, yea I know that I do lots of boyish things, and I'm a tomboy, but I'm a girl. I know I'm a girl. And so that actually grounded me a lot because, I'm like, I'm not even, you know, as sporty or as into

horror movies, or into violent video games as “Francis”, and she knows she’s a girl. And I don’t. I don’t know that I’m a girl, I pretty much know that I’m a guy. I certainly know that I’m not a girl. So that, was that was actually like really helpful to me, to like have this comparison that I don’t need to be ultra masculine to be a real man. (personal communication, September 13, 2013)

Rigidity was also perceived in his own ability to label himself as transgender, fearing that leaders in GLBT groups would give him a different label that may not feel completely fitting, an experience he had within online FTM communities. He stated:

And I, you know, and I guess this is a more recent discovery that kind of um, reinforces what I’d been afraid of all along. But was that I would go to the LGBT community and they would say, oh no, you’re not a transman. You’re you’re gender queer, or you know, you’re not trans enough. You need to do this and this and this and then we’ll take you seriously as a transman. (personal communication, September 27, 2013)

He further described his experience, stating, “Um, and so that like, that was a little eye opening for me in that, you know, the LGBT community comes with their own prejudices. And they have their own definitions that they really want to stick to” (personal communication, September 27, 2013). He went on to discuss the concept that although the term *transgender* has been helpful to give language to his gender experience, the term itself is not as important as his experienced gender. He stated:

For me, like, I always knew I was a boy. I felt like a boy on the inside, and I was able to pretty clearly articulate that. You know, the word transgender was helpful

later, but its not really what brought it together for me. (personal communication, September 27, 2013)

Lastly, Allen experienced rigidity in the interventions that are viewed as valid treatment for Gender Identity disorder. These interventions are primarily medical surgeries for bodily alterations, which Allen perceived as not fitting for him currently. He reflected on some of his personal conflict in regards to medical treatment and to his identification as transgender. In a personal blog he wrote, “Don't I, in some way, define what it is to be transgender, by continuing to have severe gender identity issues without pursuing hormone therapy and continuing to tolerate, and sometimes even enjoy, my birth-assigned gender roles?” (Online Blog F, 2012). He further explained this conflict in regards to what he perceived as limitations to surgery in changing him into a male. He stated:

What we see as treatment for transgenders, which is phalloplasty or vaginalplasty, is not really a solution. Its not because transman, transmen can't father children naturally. Um, and transwomen, who it seems to be a bigger deal for, I guess, can't carry children. I mean they can still have biological children, you know, they can like do their business in a cup and and freeze it until they're ready for that, which is a good thing. But right now the only treatment we have is sterilizing surgery that results in something that's only pleasurably functional, but not sexually functional in the sense that you're not able to create a child by, you know, sexual reproduction. (personal communication, September 27, 2013)

Silence and compromise. Allen's reaction to experiences of avoidance, invalidation, and rigidity appear to have been the development of silence and compromise around his gender identity. In childhood and adolescence he created ways to address the gender dysphoria he

experienced while maintaining secrecy around his gender identity. This included using a male name in video games, and picking a fantasized male self. He explained:

My male embodiment when... when I was a little kid was Link from The Legend of Zelda... He wasn't that tall. He wore a, wore a hat all the time so you couldn't tell how long his hair was. And he was wearing a tunic. So you couldn't tell if he actually had a package or not. (personal communication, September 6, 2013)

In another example of how he silently addressed his gender dysphoria, he explained feelings of fear that motivated secrecy of these behaviors. He stated:

But anything that was single player I entered in my username as "John". Which is derived from my middle name. You know. It was a male name. Um. And I remember being kind of ashamed, or scared that anyone would find out that I was doing this. Including my parents cause, I don't know. Scary that they would find out that I was different. Cause it was made pretty clear that being different was wrong. You know, being being different uh, would, would cut you off. That they wouldn't be proud of me if I were that kind of different. (personal communication, September 6, 2013)

Silence was also used into adulthood in order to avoid negative consequences of disclosing his transgender identity, including loss of relationships, violence, and discrimination. He described a perceived need for silence when he began dating in high school, stating:

So, so I didn't really feel safe to come out. And its like, well as long as I'm kind of not coming out I might as well form a relationship with these men. One because I'm horny. Two because I don't have a relationship with my family and I'm really looking to create an interpersonal bond that this seems like the best way

I can do it. You know, really bad teenager logic. (personal communication, September 6, 2013)

In a personal journal written during this time, Allen wrote, “Maybe that’s how people make relationships work, is by just not thinking about it” (personal communication, February 27, 2009). In addition to silence in early relationships, Allen described not participating in GLBT or Transgender community face-to-face activities, and utilizing only online support and information to protect his anonymity. He stated:

Um, and so I guess kind of going to the LBGT community but not being honest about who I was didn’t seem like a good idea. But going to the LGBT and being honest about who I was and kind of like giving thirty people, or however many it was, you know, not just this information about me, but almost the opportunity to make this well known. (personal communication, September 27, 2013)

In on an online blog he discussed what he was compromising by remaining silent. He wrote, “I’m basically trading any progress in self-actualization for keeping this relationship alive. And this isn’t the only relationship. My parents, my school-mates, potential future employers and judgment-makers have all held me back” (Online Blog F, 2012).

Even following disclosure of his transgender identity to significant others, Allen made compromises in regards to engaging in behaviors congruent with his identified gender (i.e., dress and presentation) so as to maintain relationships. An example of this kind of compromise was his choice of clothing when attending prom. He stated:

And I wanted my perfect prom. So, and I actually was reading through my diaries and, I wanted to wear a tux. And I was only wearing a dress because I was going with him and I didn’t want to make him feel bad, or look like the gay guy. Um,

but you know, I I chose to ornament myself in other ways that made me more comfortable. (personal communication, September 13, 2013)

He went on to further describe his state of mind at the time, explaining:

Which is, you know, I I'm trans, I identify this way. I really want to, you know, become physically male, but I love you so much and I just want to be together, and you know, if you want me to stay a girl then I'll stay a girl. You know, stupid, 17 year old, like, one-sided compromise. (personal communication, September 27, 2013)

He explained that even when able to dress in ways that felt comfortable, he reported that compromise in relationships with partners who did not appreciate his gender identity were experienced in others ways. He stated:

But it does come with other caveats, like, you know, if you introduce yourself to their family you still introduce yourself as female. You know. When you go out on dates you don't dress as a guy, you dress as the female date. (personal communication, September 27, 2013)

Allen stated this primary reason for compromise was indeed motivated by a need for connection.

He stated:

And, you know, and I compromised. I absolutely compromised so that I could form relationships. Uh. I, I just, I needed to be loved. And not even by, you know, a sexual partner, but by friends. You know, I needed people in my life. (personal communication, September 6, 2013)

Intragroup dynamics. Lastly, a prominent theme seemed to be the difficult experiences of intragroup dynamics in regards to Allen's feelings of displacement within larger GLBT

community. When reflecting on the attention given to transgender issues within the community, Allen stated:

Like they started adding letters. And for a while it was LGBTQ, LBGTQQIAA, and you know all that. But it kind of like, they kind of landed on LGBT, but I was around for, for that while it was happening. But even while it was happening and while they were like acknowledging you know, bisexuals and transgenders, it was pretty clear that the T was silent. That really the LGBT movement was about gays and lesbians. (personal communication, September 27, 2013)

Allen went on to comment on how this lack of attention paid to transgender issues, and his perceived identity as a “outsider” among this group created personal feelings of exclusion within the group. He stated:

Um, and you know, in terms of how to, you know, open up the LGBT community, so that it seems like less of just another in-crowd. Cause sometimes it, it can seem that way. Its like, if you’re not gay then we don’t want to have to anything to do with you. (personal communication, September 27, 2013)

Allen’s feelings of exclusion as a transman within the GLBT community added to this avoidance of these groups, and ultimately seemed to limit his network of support and confirm a sense of invisibility. He stated:

Prejudices within the LGBT community I think are really dangerous. Because if you’re an outsider, and you’re looking for a community you’re looking for, you know, sanctuary or solace, and then you go to that community and they just tell you again that you don’t belong. (personal communication, September 27, 2013)

He went on to state:

But I'm being neglected. Or my, not even, not just me, but its like my group, my section of humanness. You know, all the people like me are not being addressed with this same sensitivity and regard, and reflection. Uh, so yea, that made me feel left out. (personal communication, September 27, 2013)

In response to his feelings of exclusion, Allen stated not only perceived a need for greater inclusion of transgender issues within the GLBT rights movement, but also a need for more general change in the culture of this community to promote greater overall acceptance. He stated:

You know, the LGBT community needs to be more than just a place for people with alternate sexualities. Or, you know, alternate gender identities, it needs to embody a philosophy that everybody gets too be who they are, or who they want to be, and that everybody else's job is to let them. (personal communication, September 27, 2013)

Chapter IV: Discussion

This study was designed to obtain a deeper understanding of the experiences of formal and informal support of a female-to-male transgender individual. The study included significant background information about the participant, including gender identity, ethnicity, family relationships, both personal and interpersonal conflicts and resolutions. However, the primary focus of this study was a retrospective look at Allen's accounts of informal and formal support and an analysis of the impact and perceived shortcomings of these forms of support, with the ultimate goal of providing additional information and literature to fill the gap of information specific to the FTM transgender experience. Three prominent themes emerged from the results of this study. These included: (a) avoidance and invalidation experienced with both informal and formal support, (b) rigid boundaries regarding acceptable gender identity expression, and (c) using silence and compromise in reaction to unhelpful experiences of formal and informal support.

Invisibility: Avoidance and Invalidation

A prominent theme of Allen's experiences with both formal support and informal support in the form of significant interpersonal relationships was an avoidance reaction in regards to Allen's male identified gender and transgender identity. The avoidance reactions and lack of acknowledgement of his gender identity disclosures seemed to create feelings of invalidation and invisibility. Allen expressed a sense that, not only was what he was saying unimportant, but that who he experienced himself to be was ultimately unseen. In Allen's relationship with his parents, he did not experience them as acknowledging or believing the validity of his experience of cross-gender identification. They believed it was a phase and asked him to compromise his gender expression. Their lack of validation of his own identity and sense of self, through the use

of silence and avoidance of his expressed personhood, left him feeling, in his words, “cheated.” In many of his interpersonal relationships, Allen also experienced his gender identification as not being appreciated by his partners. In later adolescence and adulthood Allen chose to disclose his transgender identity in the face of experienced fear and anxiety about potential rejection and loss of these relationships. Partners that remained in the relationship after his disclosure seemed to have mimicked the earlier reaction of Allen’s parents, specifically a kind of conditional acceptance; maintaining the relationship but not acknowledging Allen’s personhood, a common experience of friends and family by transgender individuals (Ellis & Eriksen, 2002; Wren, 2002). Allen’s experience supports research indicating that during the process of transition, a lack of social support increases the experience of emotional distress (Budge et al., 2012).

When reaching out for support in high school, and when meeting with his psychiatrist, Allen also experienced a lack of acknowledgement of his disclosure. He reached out for support in hopes of receiving help around his distress, and in hopes of building a source of support and safety in a generally hostile and scary social environment. However, what he received was a “blip” and avoidance that communicated that what he said was either not significant, or that he could not be helped by those whom he reached out to; again making him an invisible person in his environment. It was only in Allen’s experience with a marriage and family therapist did Allen receive some follow-up about his identity development. However, this follow-up occurred after Allen was put on the defensive after his therapist’s initial reaction of laughter and seeming dismissal of his initial disclosure of his identified gender, which appeared to reaffirm the invisible nature of a significant piece of himself. This kind of avoidance of Allen’s disclosure, and minimization of his gender experience, seems consistent with the concept of *microinvalidations*, a type of microaggression defined as “communications that subtly exclude or

nullify the feelings, thoughts, or experiential reality of a person” (Smith, Shin, & Officer, 2012, p. 388).

Later, he experienced both his therapist and his psychiatrist as lacking of knowledge of transgender issues, leaving him with a perceived need to “educate them.” Even when putting in the effort to give his treating therapist the language to use when addressing him, he was confronted by her inability to “get it straight in her head,” an additional microinvalidation minimizing the importance of his gender identity, which can in turn reinforce feelings of stigmatization (Ellis & Eriksen, 2002; Gaillard, Shatell, & Thomas, 2009; Smith et al., 2012). Allen’s experience of a helping professional as lacking in knowledge of transgender issues, and needing to educate these professionals on acceptable terms and language, is a common experience for those in the transgender community (Dewey, 2008; Ellis & Eriksen, 2002; Levitt & Ippolito, 2013). Allen’s experiences with formal support also seems consistent with other studies of transgender individuals that have identified negative experiences in psychotherapy as including common characteristics of: (a) lacking a competent therapist, (b) incidents of explicit shows of hostility, and (c) addressing pathology instead of addressing personal “wholeness” (Bess & Stabb, 2009, p. 273). The lack of knowledge of transgender issues among helping professionals might have been experienced by Allen and other transgender persons, as further evidence of the invisibility of the transgender community.

Even when met with a response of unconditional acceptance from friends, disclosure invalidation was experienced as a lack of acknowledgement of the difficulty of his life because of his transgender identification. Although some friends appreciated his gender identity, they did not exhibit understanding of the distress he experienced, and will continue to experience, because of social prejudice and discrimination (Ellis & Eriksen, 2002). This very important

piece of his experience, the reason he struggled with depression, fear, and feelings of aloneness, was overlooked, and the gravity of his experience misunderstood, which research shows causes feeling of invalidation (Gaillard et al., 2009). Allen experienced validation through his involvement in online chat rooms and supportive websites created by and for the FTM transgender community, where he felt heard and his gender identity fully seen by those to whom he interacted with. It was through reading about and hearing from other transman that helped Allen to gain confirmation that his experience was real and worth addressing, a common experience within the GLBT community (Pinto, Melendez, & Spector, 2008). These acted as his primary support when his experience of formal and informal support had fallen short. This experience is consistent with studies looking at coping in GLB and transgender communities, in which development of informal social networks and online communities to exchange information and help each other through the transition process has been a useful means of obtaining needed support, (Bess & Stabb, 2009; Pinto et al., 2008; Stryker, 2008). Research also suggests that seeking social support from other transgender people and searching for helpful resources is a way in which some transgender individuals cope with distress associated with experiences of rejection from others (Budge et al., 2012).

Within the larger GLBT community, Allen perceived a lack of transgender issues represented in the movement of rights and equality, further demonstrating the themes of experiencing invisibility through avoidance, invalidation, and lack of acknowledgment of his transgender experience. Research gives credence to Allen's experience of exclusion, and the general invisibility of transgender issues within the larger GLBT community. Historically, the gay and lesbian community purposefully excluded transgender people from organization and social movements (Stone, 2009; Stryker, 2008). More current research suggests that gay and

lesbian community activists continue to struggle with understanding the transgender experience, and are continuing to work on giving equal attention to specific transgender issues (Factor & Rothlum, 2008; Stone, 2009). This can create a sense of disconnection from the larger GLBT community, thereby largely reducing access to social and community support (Factor & Rothlum, 2008).

Rigid Boundaries of Gender Expression

Allen experienced rigidity in regards to what it means to be male, what it means to be transgender, and specifically what it means to be male in the transgender community. He experienced the concept of *maleness* as needing to fit into stereotyped behaviors and presentations of typically male gender norms. Allen's own lack of fitting into these strict norms or expectations created some doubt about his own male and transgender identity. This particular experience parallel's research around gender roles in the MTF community, suggesting experiences of discouragement and limitation in areas such as career choices and social behavior, which are prescribed traditional gender expectations (Brown et al., 2012). Rigidity was further demonstrated in Allen's fears that those in the GLBT community, and with more authority, would give him a label, thereby taking away his right of self-determination through his own ability to identify himself as he felt was most fitting. This is an increasing common concern among GLBT youth, who are showing resistance to using distinct identity labels because of limitations and expectation of what these labels mean, as well as conflict between the expectations of the label and how they experience themselves. (Welle, Fuller, Mauk, & Clatts, 2008). Allen experienced this in online FTM communities, in which conflict exists in regards to what it really means to be transgender (Forshee, 2008).

Allen additionally experienced rigidity in the interventions that are viewed as valid treatment for Gender Identity disorder, most of which primarily involve medical treatment. Allen did not feel that medical treatment is currently the best avenue for him to achieve his desired maleness. This is partly because for Allen, although body dysphoria is experienced, his desire to be seen and treated as male is more important than having all the secondary sexual characteristics of a male. These alone would not make Allen feel like a man, and for him, it seems to be a drastic measure to undertake, especially when considering the limitations of such interventions in regards to male presentation, such as sustained height (Schilt, 2006). Studies around medical treatment and physical bodily alterations has been a growing area of research in the development of treatment interventions for transgender individuals, with some researchers suggesting that viewing SRS as the ultimate treatment goal is limiting (Ault & Brzuzy, 2009; Dewey, 2008). However, FTMs who have chosen to not undertake hormone therapy have faced additional hardships in their ability to not only pass, but be treated and addressed consistently as male, making medical interventions an important and ongoing issue for the FTM community (Schilt, 2006).

Silence and Compromise

Findings of this study indicate that Allen's reaction to his more negative experiences of formal and informal support was to adopt skills of silence about his gender identity. This supports research in the area of coping behaviors within the transgender community that suggest the use of emotional avoidance and hiding as a fundamental behavior early in the development of a transgender identity (Budge, Adelson, & Howard, 2013). A study by Budge et al. (2013) found that one of the ways in which their participants coped with fear and distress around transition was to engage in *avoidant coping mechanisms*, including denying their transgender identity to

avoid rejection of their identity from others. Additional research on the impact of secrecy on psychosocial well-being suggests that an adolescent's act of keeping a secret contributes to longer struggles with depressive mood, low self-esteem, low self-control, loneliness, decreased clarity about oneself, and poor quality of parental relationships (Frijns & Finkenauer, 2009). This kind of silence and concealment of important elements of the self typically leads to a general decrease in the well-being and satisfaction level within relationships (Uysal, Lin, Knee, & Bush, 2012). The literature is consistent with the feelings of distress experienced by Allen in keeping his gender identity secret from others, as well as the long-term stress he experienced in important relationships.

Allen believed that his earliest disclosures and seeking of support from his parents were silenced. However, even without adequate support he developed ways to address his gender dysphoria while keeping his identity a secret. The results of one particular study on coping mirrors Allen's use of compromise, finding that in trying to address their gender dysphoria, transgender individuals also engage in behavior that is more congruent with their identified gender (i.e., clothing) while hiding these behaviors from others (Budge et al., 2012; Levitt & Ippolito, 2013). In Allen's childhood this included secretly using a male name in video games, and picking a fantasized male self. Although choosing to engage in these behaviors to address gender dysphoria, he did these in secret and in fear that his parents would find out and "cut him off." Research suggests it is common for transgender and genderqueer individuals to begin to present themselves in ways more congruent to their identified gender or trans identity before coming out to others. (Factor & Rothblum, 2008).

Later compromises made by Allen included limitations in regards to wearing clothing that was congruent with his desired gender expression, not attending GLBT or Transgender

community face-to-face activities, and utilizing only online support and information. Allen's perceived need to make compromises around his gender identity was done in order to maintain important relationships, avoid potential risks to his future career, and avoid potential risks to his personal safety. As Allen put it, he "needed people in [his] life," and compromised and denied pieces of himself and in order to avoid feeling and being alone.

Researchers Hendricks and Testa (2012) state:

For transpersons, loneliness may result from rejection by family members, friends, or coworkers who are unwilling to accept their trans status. Isolation may be compounded by few options for support in a society that is generally not accepting of gender nonconformity. (p. 464)

Allen's relationship experiences and lack of social support seem to clearly demonstrate the distress associated with loneliness experienced due to not only the rejection from important others and little support alternatives, but also due to motivations to conceal pieces of the self maintain to relationships (Uysal et al., 2012).

Intragroup Dynamics

Research in the area of group dynamics suggests that the level of inclusion of members within an identified group is influenced by how well a member represents the central goals of the identified group (Ellemers & Jetten, 2013; Steinel et al., 2010). Allen experienced his position within the greater GLBT community was one of an outsider. He did not perceive transgender people as being treated with the same amount of "sensitivity and regard" as the identified gay and lesbian community members. When considering Allen's experience of exclusion and disregard of the GLBT community for the transgender experience, it appears that the concerns and issues specific to the transgender community are not perceived by GLBT leaders to fully align with

those of this larger community. This again seems to reflect the historical exclusion of transgender people from gay and lesbian social movement (Stone, 2009; Stryker, 2008), and the ongoing difficulty of GLBT community activists to understand and connect with the transgender community (Factor & Rothblum, 2008).

Issues of Psychosocial Development

It is very important to also examine Allen's experiences of his course through the stages of psychosocial development. Erickson theorized that each person develops through eight psychosocial stages, during which personal development is influenced by the interaction between a person's characteristics and support provided through their social environment (Berger, 2000). Much of Allen's accounts of his male identity development and experience of support are reflected in his accounts of adolescent and into the present day experiences (early adulthood). Erickson identified adolescence as a stage in which an individual is attempting to figure out who they are in regards to their political, sexual, and career identities, but that people in this stage are often confused about what roles to play (*identity vs. role confusion*). This is reflected in Allen's accounts of finding his way through romantic, familial, and social relationships in regards to the gender role he felt safest to portray. In his later adolescence and now into his early adulthood, his primary relationship conflicts are related to managing his gender identity through silence and compromise in his search for companionship and love from others while avoiding isolation and rejection (*intimacy vs. isolation*). Especially when looking at Allen's experience of coping behaviors of silence and compromise, and his experience of rigid boundaries of gender expression, it seems important to also consider how his developmental stage influenced these experiences and behaviors, and how his ongoing progress through future developmental stages will influence his continued identity development.

Emerging Hypotheses

Prominent themes that surfaced from the results of this case study, included: (a) avoidance and invalidation experienced with both informal and formal support, (b) rigidity in acceptable gender identity expression, and (c) using silence and compromise in reaction to unhelpful experiences of formal and informal support. When considering these themes the following hypotheses seem to emerge:

1. Avoidance behaviors in therapeutic and other significant relationships can create feelings of invisibility, disconnection, defensiveness, and invalidation of the transgender individual's gender experience.
2. Experiences and or perceived rigidity in regards to gender expression within the Transgender and larger GLBT communities can lead to feelings of distress, disconnection, and avoidance behaviors.
3. Experienced and perceived lack of formal and informal support can increase use of avoidance behaviors, and compromising behaviors for transgender individuals in order to avoid expected negative consequences of identity disclosures.

Limitations and Implications for Future Research

Limitations of the study. While the criteria used in selecting the participant was done so in an attempt to obtain rich information about the experience of one female-to-male transgender individual, due to the case study format, the results cannot be said to generalize to the experience of the greater transgender population.

Although the selected participant met criteria allowing him to partake in the study, he did not define himself as the “quintessential” transman. This description of himself was associated

with his perception of not experiencing body dysphoria as intensely as some other FTMs. This led him to a decision to not obtain medical interventions at this time, including hormone therapy, or surgeries to alter either his physical appearance or born gender. While the participant did engage in psychotherapy, it was not initiated for the purpose of addressing transgender issues specifically, although transgender issues were prominent themes associated with his presenting problem in therapy (i.e., relationship distress). Additionally, though the participant was able to report on his experience of support in the form of online transgender communities and websites, he did not have direct face-to-face contact with GLBT groups or activities. This lack of experience limits the ability of this study to speak to the possible effectiveness or impact of greater involvement with GLBT groups as a form of support available to the transgender community.

It should also be noted that because the information given by the participant is subjective, their reported experiences might not be a true and accurate account of the actual details of the events spoken about. Additionally, while the interview was audio recorded for accuracy of the participant's verbal reports, it is possible that the completed case study may not fully capture the true experience of the participant possibly due to their inability to accurately recollect or verbalize their experience, or due to bias in the researcher's interpretations of the interview data (Berg, 2004; Seidman, 2008; Stake, 1995).

Implications for future research. The use of a case study format allows for an in-depth account of the participants' subjective experience, including responses, reactions, and reflections on these personal experiences. Although case studies of a single participant do not typically provide conclusions that can be generalized to a wider population, when added to a group of

other similar cases, can add to the overall knowledge and collection of data about a particular population from which more general knowledge can then be pulled (Stake, 1995).

In gathering information about the experiences of a female-to-male transgender individual within the context of experiences of formal and informal support, this study seems to have highlighted some areas of attention for future research. Given Allen's experience of avoidance and lack of acknowledgement by those to whom he disclosed his transgender identity when seeking support, one area of needed attention seems to be in provision of support to transgender youth and adults. This might include trainings on common symptoms of gender dysphoria, and how to manage disclosures of transgender identity made by individuals. Considering the results of this study, these trainings would seem beneficial for clinicians, as well as other professions that interact with youth in a position of authority, including school, and other activity or recreation programs.

Given the feelings of disconnection from the larger GLBT community experienced by Allen, further research might take a deeper look at the utility of all encompassing GLBT support groups or activities in relation to specific gender or sexual orientation subgroups that are included under this umbrella. Issues of macrobelonging and micobelonging are both important in creating available and effect social support opportunities for transgender people. In addition to the quality of interactiongroups within the GLBT community, the impact and importance of Allen's significant interpersonal relationships (outside of the GLBT community) greatly impacted his gender expression and behavior, and the course of his transition. This suggests the need for more specific research in the area of influences of interpersonal relationships on gender expression and transition for transgender individuals, in addition to the more recent research on coping styles during gender transition.

When specifically considering Allen's experience in formal psychotherapy, his frequent experiences of the avoidant behavior and lack of knowledge about transgender issues of therapists is quite noteworthy. Therapists have an ethical responsibility to demonstrate multicultural competence in regards to the issues pertinent to the client's presenting problems, and interacting cultural identities. This includes a therapist's duty to attend to their own level of knowledge of a particular cultural identity issue or concern, as well as personal attitudes or issues of countertransference that may occur. This can help to avoid or minimize commission of the type of microaggressions, rejection behaviors, and invalidations experienced by Allen. Allen's experiences in formal psychotherapy highlight greater clinical implications in regards to the client's experience of therapists who may not demonstrate acceptable standards of multicultural competence. Allen's specific clinical experiences reflected reactive feelings of disconnection and defensiveness. Future research might then be warranted in regards to competency and training when working with the transgender community. When specifically looking at Allen's experience of avoidance in these relationships, research might also focus on the effect of avoidance behaviors by clinicians and its impact on the therapeutic relationship, and client success in therapy.

During the course of this study, the APA published and released the DSM-5 (2013), with changes to the name and categorizing of the previous diagnosis of GID. Individuals seeking treatment for issues of gender identity will receive the new diagnosis of Gender Dysphoria, a diagnosis and description of symptoms aimed at better describing a range of dysphoria, as opposed to a specific gender identity, thereby widening the scope of individuals who may meet criteria for this diagnosis (APA Factsheet, 2013). Researchers within the psychological community might direct future studies on clinician competency in utilizing this new diagnosis,

and its impact on the use of medical interventions by those who receive it. When considering Allen's experience of conflict in regards to the limitations and rigidity of labels and terms (diagnostic or otherwise), future research might also assess how accurately, or how inclusive, the new diagnosis of Gender Dysphoria is experienced by those within the transgender community.

Conclusion

The goal of this study was to obtain an in-depth understanding of the experiences of formal and informal support of a female-to-male transgender individual for the purpose of adding to the overall knowledge of this under-researched group. The study included background about the participant, such as gender identity, ethnicity, family relationships, and conflicts and resolutions experienced personally and interpersonally. The principal focus of this study was an analysis of the experience of informal and formal support. Data analysis indicated four prominent themes of the participant's experience of formal and informal support: (a) avoidance and invalidation experienced with both informal and formal support, (b) rigidity in acceptable gender identity expression, (c) using silence and compromise in reaction to unhelpful experiences of formal and informal support, and (d) intragroup dynamics of exclusion.

The case study reported here highlights important areas of future research including: (a) the effectiveness in provision of support to transgender youth and adults, (b) the utility of all encompassing GLBT support groups/activities in relation to specific groups of gender or sexual orientation, (c) potential influences of interpersonal relationships on gender expression and gender transition, (d) clinician cultural competency on transgender issues, and (e) the accuracy and inclusiveness of the new diagnosis of Gender Dysphoria as experienced by the transgender community.

REFERENCES

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. text rev.). Washington, DC: American Psychiatric Association.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Association.
- American Psychiatric Association. (2013). *Gender dysphoria* [factsheet]. Retrieved from <http://www.dsm5.org/Documents/Gender%20Dysphoria%20Fact%20Sheet.pdf>
- Angarella, J. (2009). *An exploration of the shared experiences of transgender women in substance abuse treatment*. (Unpublished dissertation). Walden University.
- Ault, A., & Bruzuzy, S. (2009). Removing gender identity disorder from the diagnostic and statistical manual of mental disorders. *Social Work, 54*, 187-189. doi: 10.1093/sw/54.2.187
- Bartlett, N. H., & Vasey, P. L. (2006). A retrospective study of childhood gender-atypical behavior in Samoan Fa'afafine. *Archives of Sexual Behavior, 35*, 659-666. doi: 10.1007/s10508-006-9055-1
- Beam, C. (2007). *Transparent: Love, family, and living the t with transgender teenagers*. Orlando, FL: Harcourt.
- Berch, M. C. (Producer) & Muska, S., & Olafsdottir, G. (directors). (1998). *The Brandon Teena story* [Motion Picture]. USA: Bless Bless Productions.
- Berg, B. L. (2004). *Qualitative research methods for social sciences*. Boston, MA: Pearson Education.
- Berger, K. S. (2000). *The developing person through childhood and adolescence, (5th ed.)*. New York, NY: Worth Publishers.
- Bess, J. A., & Stabb, S. D. (2009). The experiences of transgendered persons in psychotherapy: Voices and recommendations. *Journal of Mental Health Counseling, 31*(3), 264-282. Retrieved from <http://web.ebscohost.com.lib.pepperdine.edu/ehost/pdfviewer/pdfviewer?sid=8ab50b4d-9a0c-402e-9538-9b5fea7a3e75%40sessionmgr4003&vid=5&hid=4114>
- Bockting, W. O., & Ehrbar, R. (2006). Commentary: Gender variance, dissonance, or identity disorder? *Journal of Psychology & Human Sexuality, 17*(3), 125-134. doi: 10.1300/J056v17n03_08
- Borras, L., Huguelet, P., & Eytan, A. (2007). Delusional "pseudotranssexualism" in schizophrenia. *Psychiatry, 70*(2), 175-179. doi: 10.1521/psyc.2007.70.2.175

- Bower, H. (2001). The gender identity disorder in the DSM-IV classification: A critical evaluation. *Australian & New Zealand Journal of Psychiatry*, *35*, 1-8. doi: 10.1046/j.1440-1614.2001.00859.x
- Brown, C. B., Dashjian, L. T., Acosta, T. J., Mueller, C. T., Kizer, B. E., & Trangsrud, H. B. (2012). The career experiences of male-to-female transsexuals. *The Counseling Psychologist*, *40*(6), 868-894. doi: 10.1177/001100001430098
- Budge, S. L., Adelson, J. L., & Howard, K. A. S. (2013). Anxiety and depression in transgender individuals: The roles of transition, status, loss, social support, and coping. *Journal of Consulting and Clinical Psychology*, *81*(3), 545-557. doi: 10.1037/a0031774
- Budge, S. L., Katz-Wise, S. L., Tebbe, E. N., Howard, K. A. S., Schneider, C. L., & Rodriguez, A. (2012). Transgender emotional and coping processes: Facilitative and avoidant coping throughout gender transitioning. *The Counseling Psychologist*, *41*(4), 601-647. doi: 10.1177/0011000011432753
- Ceglie, D. D., & Thummel, E. C. (2006). An experience of group work with parents of children and adolescents with gender identity disorder. *Clinical Child Psychology and Psychiatry*, *11*(3), 387-396. doi: 10.1177/1359104506064983
- Cohen-Kettenis, P. T., Owen, A., Kaijser, V. G., Bradley, S. J., & Zucker, K. J. (2003). Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: A cross-national, cross-clinic comparative analysis. *Journal of Abnormal Child Psychology*, *3*, 41-53. doi: 10.1023/A:1021769215342
- Dewey, J. M. (2008). Knowledge legitimacy: How trans-patient behavior supports and challenges current medical knowledge. *Qualitative Health Research*, *18*(10), 1345-1355. doi: 10.1177/1049732308324247
- Ehrbar, R. D., Witty, M. C., Ehrbar, H. G., & Bockting, W. O. (2008). Clinician judgment in the diagnosis of gender identity disorder in children. *Journal of Sex & Marital Therapy*, *34*(5), 385-412. doi: 10.1080/00926230802219398
- Ellis, K. M., & Eriksen, K. (2002). Transsexual and transgenderist experiences and treatment options. *The Family Journal: Counseling and Therapy for Couples and Families*, *10*(3), 289-299. doi: 10.1177/10680702010003005
- Ellemers, N., & Jetten, J. (2013). The many ways to be marginal in a group. *Personality and Social Psychology Review*, *17*(1), 3-21. doi:10.1177/1088868312453086
- Factor, R., & Rothblum, E. (2008). Exploring gender identity and community among three groups of transgender individuals in the United States: MTFs, FTMs, and genderqueers. *Health Sociology Review*, *17*, 235-253. doi: 10.5172/hesr.451.17.3.235

- Feder, E. K. (1997). Disciplining the family: The case of gender identity disorder. *Philosophical Studies*, 85, 195-211. doi: 10.1023/A:1004275024875
- Feinberg, L. (1996). *Transgender warriors: Making history from Joan of Arc to Dennis Rodman*. Boston, MA: Beacon Press.
- Feinberg, L. (2006). Transgender liberation: A movement whose time has come. In S. Stryker, & S. Whittle (Eds.), *The transgender studies reader* (pp. 205-220). New York, NY: Routledge, Taylor & Francis.
- Fenway Health. (2010). *Glossary of gender and transgender terms*. Retrieved from http://www.fenwayhealth.org/site/DocServer/Handout_7C_Glossary_of_Gender_and_Transgender_Terms__fi.pdf
- Fink, P. J. (2006). Sexual and gender identity disorder: Discussion of questions for the DSM-V. *Journal of Psychology & Human Sexuality*, 17(3), 117-123. doi: 10.1300/J056v17n03_07
- Flowers, P., & Langdrige, D. (2007). Offending the other: Deconstructing narratives of deviance and pathology. *British Journal of Social Psychology*, 46, 679-690. doi: 10.1348/014466607X177713
- Forshee, A. S. (2008). Transgender men: A demographic snapshot. *Journal of Gay & Lesbian Social Services*, 20(3), 221-236. doi: 10.1080/10538720802235229
- Frijns, T., & Finkenauer, C. (2009). Longitudinal associations between keeping a secret and psychosocial adjustment in adolescence. *International Journal of Behavioral Development*, 33(2), 145-154. doi: 10.1177/0165025408098020
- Gaillard, L. M., Shatell, M. M., & Thomas, S. P. (2009). Mental health patients' experiences of being misunderstood. *Journal of the American Psychiatric Nurses Association*, 15(3), 191-199. doi: 10.1177/1078390309336932
- Gay & Lesbian Alliance Against Defamation. (2007). *GLAAD media reference guide* (7th ed.). Retrieved from <http://www.glaad.org/Document.Doc?id=25>
- Gender Identity Research and Education Society. (2008). *Glossary terms used in connection with gender variance*. Retrieved from www.gires.org.uk
- Haraldsen, I. R., & Dahl, A. A. (2000). Symptom profiles of gender dysphoric patients of transsexual type compared to patients with personality disorders and healthy adults. *Acta Psychiatrica Scandinavica*, 102, 276-281. doi: 10.1016/j.psychres.2005.05.014
- Heath, R. A. (2006). *The praeger handbook of transsexuality: Changing gender to match mindset*. Westport, CT: Praeger.

- Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the minority stress model. *Professional Psychology: Research and Practice, 43*(5), 460-467. doi: 10.1037/a0029597
- Isreal, G. E., & Tarver, D. E. (1997). *Transgender care: Recommended guidelines, practical information, & personal accounts*. Philadelphia, PA: Temple University Press.
- Kennedy, P. (2007). *The first man-made man: The story of two sexes, one love affair, and a twentieth-century revolution*. New York, NY: Bloomsbury, USA
- Kessler, L. E., & Waehler, C. A. (2005). Addressing multiple relationships between clients and therapists in lesbian, gay, bisexual, and transgender communities. *Professional Psychology: Research and Practice, 36*(1), 66-72. doi: 10.1037/0735-7028.36.1.66
- LaSala, M. C. (1997). Client satisfaction: Consideration of correlates and response bias. *Families in Society, 78*(1), 54-64. doi: 10.1606/1044-3894.737
- Levine, S. B., & Solomon, A. (2009). Meanings and political implications of “psychopathology” in a gender identity clinic: A report of 10 cases. *Journal of Sex & Marital Therapy, 35*, 40-57. doi: 10.1080/00926230802525646
- Levitt, H. M., & Ippolito, M. R. (2013). Being transgender: Navigating minority stressors and developing authentic self-presentation. *Psychology of Woman Quarterly, 00*(0), 1-19. doi: 10/1177/0361684313501644
- Megeri, D., & Khoosal, D. (2007). Anxiety and depression in males experiencing gender dysphoria. *Sexual and Relationship Therapy, 22*(1), 77-81. doi: 10.1080/02699200600565905
- National Coalition of Anti-Violence Programs. (2008). *Anti-lesbian, gay, bisexual and transgender violence in 2007* (2008 release ed.) Retrieved from http://www.ncavp.org/common/document_files/Reports/2007HVRReportFINAL.pdf
- National Coalition of Anti-Violence Programs. (2012). *Lesbian, gay, bisexual, transgender, queer and HIV-affected hate violence in 2012*, (2013 release edition). Retrieved from http://www.avp.org/storage/documents/ncavp_2012_hvreport_final.pdf
- Olyslager F., & Conway, L. (2007, September). *On the calculation of the prevalence of transsexualism*. Paper presented at the meeting of WPATH 20th International Symposium, Chicago, Illinois.
- Pinto, R. M., Melendez, R. M., & Spector, A. Y. (2008). Male-to-female transgender individuals building social support and capital from within a gender-focused network. *Journal of Gay & Lesbian Social Services, 20*(3), 203-220. doi: 10.1080/10538720802235179

- Sanchez, F. J., & Vilain, E. (2009). Collective self-esteem as a coping resource for male-to-female transsexuals. *Journal of Counseling Psychology, 56*(1), 202-209. doi: 10.1037/a0014573
- Schilt, K. (2006). Just one of the guys?: How transmen make gender visible at work. *Gender & Society, 20*(4), 465-490. doi: 10.1177/0891243206288077
- Seidman, I. (1998). *Interviewing as qualitative research: A guide for researchers in education and the social sciences*. New York, N.Y.: Teachers College Press.
- Smith, L. C., Shin, R. Q., & Officer, L. M. (2012). Moving counseling forward on LGB and transgender issues: Speaking queerly on discourses and microaggressions. *The Counseling Psychologist, 40*(3), 385-408. doi: 10.1177/0011000011403165
- Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, C.A.: Sage.
- Steinel, W., Van Kleef, G. A., Knippenberg, D. V., Hogg, M. A., Homan, A. C., & Moffitt, G. (2010). How intragroup dynamics affect behavior in intergroup conflict: The role of group norms, prototypicality, and need to belong. *Group Processes Intergroup Relations, 13*(6), 779-794. doi: 10.1177/1368430210375702
- Stone, A. L. (2009). More than adding a T: American lesbian and gay activists' attitudes towards transgender inclusion. *Sexualities, 12*(3), 334-354. doi: 10.1177/1363460709103894
- Stryker, S. (2008). *Transgender history*. Berkeley, CA: Perseus Books Group.
- Sue, S., Zane, N., Hall, G. C., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525-548. doi: 10.1146/annurev.psych.60.110707.163651
- University of California, Berkeley (2013). Gender equity resource center: Definition of terms. Retrieved from http://geneq.berkeley.edu/lgbt_resources_definiton_of_terms
- Uysal, A., Lin, H. L., Knee, R., & Bush, A. L. (2012). The association between self-concealment from one's partner and relationship well-being. *Personality and Social Psychology Bulletin, 38*(1), 39-51. doi: 10.1177/0146167211429331
- Welle, D. L., Fuller, S. S., Mauk, D., & Clatts, M. C. (2008). The invisible body of queer youth. *Journal of Lesbian Studies, 10*(1-2), 43-71. doi: 10.1300/J155v10n01_03
- Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence-based practice in mental health services. *American Psychologist, 62*(6), 563-574. doi: 10.1037/0003-066X.62.6.563

- White, T., & Ettner, R. (2007). Adaptation and adjustment in children of transsexual parents. *European Child & Adolescent Psychiatry, 16*(4), 215-22. doi: 10.1007/s00787-006-0591-y
- Winters, K. (2006). Gender dissonance. *Journal of Psychology & Human Sexuality, 17*(3), 71-89. doi: 10.1300/J056v17n03_04
- World Professional Association for Transgender Health, Inc. (2001). *The Henry Benjamin international gender dysphoria associations standards of care for gender identity disorders* (6th ed.). Retrieved from <http://wpath.org/Documents2/socv6.pdf>
- World Professional Association for Transgender Health, Inc. (2012). *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People*. Retrieved from http://www.wpath.org/uploaded_files/140/files/Standards%20of%20Care,%20V7%20Full%20Book.pdf.
- Wren, B. (2002). 'I can accept my child is transsexual but if I ever see him in a dress I'll hit him': Dilemmas in parenting a transgendered adolescent. *Clinical Child Psychology and Psychiatry, 7*(3), 377-397. doi: 10.1177/1359104502007003006

APPENDIX A

Glossary of Terms

Bisexual: refers to any person who is attracted to both those who are of the same and opposite sex as their identified gender.

Cisgender: someone whose gender identity and expression are the same as their birth sex (Fenway Health, 2010)

Closeted: not being open about one's sexual orientation (GLAAD, 2007).

Coming Out: refers to accepting one's sexual orientation and or transgender identity; which may include revealing these aspects of one's self to others (GLAAD, 2007).

Gay and Lesbian: refers to an attraction to others of the same sex in relation to their identified gender (GLAAD, 2007). For example, the term *gay* would typically be used to refer to a FTM transgender person who is attracted to men, and the term *lesbian* would typically be used to refer to an MTF transgender person who is attracted to women (GLAAD, 2007).

Gender Dysphoria: refers to feelings of discomfort associated with incongruence between one's gender identity and one's birth sex (Isreal & Tarver, 1997).

Gender Expression: used to describe an individual's "external manifestation of one's gender identity" (GLAAD, 2007, p. 6). This includes the persons' style of dress, choice of hairstyle, behavior and mannerisms, as well as tone of voice or use of language. These characteristics can vary tremendously in their degree of masculinity and femininity. It is typically the case that the gender expression of a transgender person most matches that of their gender identity (GLAAD, 2007).

Gender Identity: describes an individual's "internal, personal sense of being a man or a woman" (GLAAD, 2007, p. 6).

Gender Variant/ Gender Queer: not conforming to social expectations of gender expression (University of California, Berkeley, 2013)

GLBT: acronym for Gay, Lesbian, Bisexual, Transgender (GLAAD, 2007).

Heterosexual/Straight: refers to an attraction to others who are the opposite sex in relation to one's identified gender (GLAAD, 2007).

Homophobia: refers to feelings of fear associated with lesbians or gay men.

Intersex: describes a person who's "biological sex is ambiguous" (GLAAD, 2007, p. 7); due to variations in genetic, hormonal, and anatomical characteristics.

Male-to-Female (MTF) and Female-to-Male (FTM): use the terms used to describe and identify a transgender individual's sex in relation to their gender identity (GLAAD, 2007). For example, an FTM transgender person who uses this term is describing himself as a person who was born biologically as a female, but identifies as a male. Notice that in this case, the male pronoun (i.e., he) is used to refer to this person in relation to his gender identity and not his sex.

Passing: refers to a person's ability to be recognized by others as the gender consistent with their expressed gender identity (i.e., an FTM individual would be recognized by others as a male and not as a female in transition to being male).

Sex: defined and used to describe the biological characteristics of an infant that is assigned at birth. These include, chromosomal, hormonal, reproductive organs, and genitals characteristic of either the male or female sex (Gay & Lesbian Alliance Against Defamation [GLAAD], 2007).

Sexual Orientation: refers to an individual's romantic, physical, and sexual attraction to another person, and is considered to exist separately from a person's gender identity (GLAAD, 2007). This means that a transgender person may identify as straight, lesbian, gay, or bisexual (Gender Identity Research and Education Society [GIRES], 2008).

Sex Reassignment Surgery (SRS): a surgical intervention in which one alters their physical sex (GLAAD, 2007).

Transgender: one that is most generally used to describe an individual whose gender identity as male or female does not match their birth assigned sex (GLAAD, 2007).

Transition: refers to the process of a transgender person changing from their birth sex to their identified gender (GLAAD, 2007). The transition process includes revealing one's identity as a transgender individual to their family, friends, and employer, especially if or when beginning to live as one's identified gender. It also includes adjusting to hormone therapy and optional body alterations, as well as changes to important legal documents.

Transman: someone who's birth assigned sex was female but who identifies as the male gender (Fenway Health, 2010)

Transphobia: refers to feelings of fear associated with transgender people.

Transsexual: term originating in the medical and psychological community that refers to cross-gender identification (GLAAD, 2007).

Transvestite/Cross-Dressing: refers to wearing clothing typical of that of the opposite sex on a non-consistent basis. Cross-dressing is not always tied to sexual activity, nor is it associated with one's sexual orientation (GLAAD, 2007).

APPENDIX B

Advertisement for Participation in Study

**Going from “F” to “M” –
Experiences with Formal and Informal Support: A Case Study of a Female-to-Male Transgender Individual**

What it is: A research case study to gain insight into the journey through gender transition from Female to Male, and the experience of seeking and receiving supportive services.

Conducted by Clinical Psychology Doctoral Student at Pepperdine University, Jessica Magallanes, M.A.

What it entails: One-on-one interviews with the purpose of obtaining description of your background and history, especially as it pertains to the decision to participate in supportive services, how services have been experienced, and the usefulness of these services.

Participation will require an initial phone screening, a commitment of three 90-minute face-to-face interviews and some e-mail contact.

Am I a good fit: Requirements for consideration to participate include:

- Identification as a female-to-male transgender person
- Be **at least** 21 years-old at the time of the first interview
- Have begun transition within the past 10 years but not sooner than 3 years
- Have utilized supportive services and/or help resources for at least 3 years as an adult
- Have participated in counseling services for least 2 years
- Have knowledge and experience of transgender culture (i.e., social network of transgender individuals; social events; community activism)
- Free of disabling depression, anxiety, or other mental disorders at the present time.
- Availability for interviews on Monday and/or Friday during afternoon or early evening hours

What’s in it for Me: Compensation of a \$25 Visa gift card at the end of each face-to-face interview, and a \$50 Visa gift card for fulfillment of participation needed for completion of the study.

While no other direct benefits are guaranteed, as a participant in this study you might gain knowledge about the impact of supportive services in your life. There may be also be benefit to the transgender community or to professionals, to the extent the study produces knowledge or information that is useful to researches or clinicians.

How do I get involved or find out more: Contact the researcher via Email at [REDACTED]@gmail.com; subject line “Research Study”.

APPENDIX C

Scripts: Email Contact with Participant

Email Script: Response to Initial Inquiry to Study Advertisement

Dear [name of inquiring individual],

Thank you for responding the Research Study advertisement.

First, I would like to briefly introduce myself and tell you a little more about my study.

My name is Jessica Magallanes. I am a doctoral student attending Pepperdine University's Clinical Psychology Doctoral Program. As per our program requirements, I am currently working to complete my doctoral dissertation, under the direction of Dr. Shelly Harrell, Ph.D. I have chosen to conduct a case study of a Female-to-Male Transgender individual with the objective of gaining an in-depth retrospective account of the journey through experiences of formal and informal support.

Included in this email you will find a document outlining a Description of the Study. Please read this document closely. If after reading the description you have a continued desire to participate in the study the next step would be for us to speak on the phone for an Initial Screening Interview. This interview would serve the purpose of aiding me (the researcher) in ensuring that your possible participation in this study will be mutually beneficial. If at the end of this phone screening it appears that that you meet requirements for participation, and if you do indeed wish to participate in the study, this telephone call will also allow us to schedule the date and times for our interviews to be conducted.

If you agree to this, please respond with the phone number which would be best to contact you at. Below you will find a list of time slots for the phone call. In your email response please also indicate which, if any, of these times would be most convenient for me to contact you.

[list of dates and times]

If, after further thought, you have decided that participation in this study is not right for you, please also respond to this email indicating such.

Also attached to this email is a list of local support services is included with the sole intention of providing some information on local community resources should you ever find yourself in need of additional or future support.

Once again, thank you so much for your interest in learning more about this study. If you have any questions feel free to email me.

Sincerely,

Jessica Magallanes, M.A. (Principal Investigator)
Clinical Psychology Doctoral Student
Pepperdine University, GSEP - West Los Angeles
[REDACTED]@gmail.com

Email Script: Response to Initial Inquiry to Study Advertisement When a Participant has been chosen

Dear [name of inquiring individual],

Thank you for responding the Research Study advertisement.

First, I would like to briefly introduce myself and tell you a little more about my study.

My name is Jessica Magallanes. I am a doctoral student attending Pepperdine University's Clinical Psychology Doctoral Program. As per our program requirements, I am currently working to complete my doctoral dissertation, under the direction of Dr. Shelly Harrell, Ph.D. I have chosen to conduct a case study of a Female-to-Male Transgender individual with the objective of gaining an in-depth retrospective account of the journey through experiences of formal and informal support.

Unfortunately a participant has already been chosen for this study. However, if for some reason this person is unable to participate in this study until its completion there will be an additional search for a study participant. Should this occur you may be contacted by email to inquire about possible continued interest in participation. Please respond to this email if you DO NOT wish to be contacted in the future should an additional participant be needed.

Also attached to this email is a list of local support services is included with the sole intention of providing some information on local community resources should you ever find yourself in need of additional or future support.

Again, thank you so much for your interest in this study.

Sincerely,

Jessica Magallanes, M.A. (Principal Investigator)
Clinical Psychology Doctoral Student
Pepperdine University, GSEP - West Los Angeles
[REDACTED]@gmail.com

Email Script: Inquiry of Continued Interest if Additional Participant is needed

Dear [name of inquiring individual],

My name is Jessica Magallanes. I am a doctoral student attending Pepperdine University's Clinical Psychology Doctoral Program, and the principal researcher of a case study of a Female-to-Male Transgender individual.

On (date of initial email inquiry) you sent an email response indicating an interest in being a participant of this study. At the time of your email inquiry a participant had already been selected. However, circumstances are such that a new participant is needed for the study.

In the case that you have continued interest in being a participant for this case study, I have included in this email a document outlining a Description of the Study. Please read this document closely. If after reading the description you have a continued desire to participate in the study the next step would be for us to speak on the phone for an Initial Screening Interview. This interview would serve the purpose of aiding me (the researcher) in ensuring that your possible participation in this study will be mutually beneficial. If at the end of this phone screening it appears that you meet requirements for participation, and if you do indeed wish to participate in the study, this telephone call will also allow us to schedule the date and times for our interviews to be conducted.

If you agree to this, please respond with the phone number which would be best to contact you at. Below you will find a list of time slots for the phone call. In your email response please also indicate which, if any, of these times would be most convenient for me to contact you.

[list of dates and times]

If, after further thought, you have decided that participation in this study is not right for you, please also respond to this email indicating such.

I do not hear from you in the time of 1 week, I will assume that you are no longer interested in being a participant and will make no further contact.

Thank you again.

Sincerely,

Jessica Magallanes, M.A. (Principal Investigator)
Clinical Psychology Doctoral Student
Pepperdine University, GSEP - West Los Angeles
[REDACTED]@gmail.com

APPENDIX D

Description of the Study

Experiences with Formal and Informal Support: A Case Study of a Female-to-Male Transgender Individual

The overall purpose of this research case study is to gain an in-depth retrospective account of the journey through experiences of formal and informal support in transitioning from the female to male gender. The use of one-on-one interviews will allow for greater information and detailed accounts of the experience of seeking and receiving support as a transgender person. The study will include a brief description of background and history, especially as it pertains to the decision to seek support, how support received was experienced, and what factors contributed to positive experiences.

To be considered for participation a candidate must meet the following requirements: (a) identify as a female-to-male transgender person, (b) be at least 21 years-old at the time of the first interview, (c) have begun transition within the past 10 years but not sooner than 3 years, (d) have utilized supportive services and/or help resources for at least 3 years as an adult, (e) have participated in counseling services for least 2 years, (f) have knowledge and experience of transgender culture (i.e., social network of transgender individuals; social events; community activism), (g) have no current significant struggles with issues related to depression or anxiety, (h) be availability for interviews on Monday and/or Friday during afternoon or early evening hours.

Participation will involve engaging in three 90 minute semi-structured in-depth one-on-one interviews with the researcher, as well as some email contacted with the researcher for clarification purposes during the writing process. All interviews will be audio recorded. The first interview will gather information about pertinent historical, familial, psychological, medical, and cultural background factors. Subsequent interviews will be steered specifically towards detailed accounts of experiences of formal support (e.g., counseling, medical services, organizational participation, etc.), informal support (e.g., online resources, significant relationships, informal group meetings, etc.), and reflection on these experiences. To protect the identity of the participant, all data will be de-identified, and all information that may permit identification of the participant (i.e., names, dates, and memberships in organizations) will be changed. Although it is not a requirement for participation, journal/diary entries or letters that speak to your experience with support services as a Transman would likely help to tell your story, and copies of such materials may be requested by the researcher. Again, this is not required, and complying with this request will be completely optional.

Compensation for participation in the study will include a \$25 Visa gift card at the end of each face-to-face interview, and a \$50 Visa gift card for their fulfillment of participation needed for completion of the study (not to exceed 3 months following the final interview). Face-to-face interviews shall be conducted at the Pepperdine University Clinic located in West Los Angeles on Mondays and/or Fridays during regular business hours. You will need to provide your own transportation to and from the interviews.

While no other direct benefits are guaranteed, as a participant in this study you might gain knowledge about the impact of supportive services in your life. There may also be benefit to the

transgender community or to professionals, to the extent the study produces knowledge or information that is useful to researchers or clinicians.

Participation in this study poses no more than minimal risk comparable to that encountered in daily life or in routine psychological testing. However, there are some risks and discomforts that might be associated with this research. Recollection of negative or difficult events, thoughts, or emotions that are discussed during the course of participation in this study may cause some distress for the participant. If it becomes evident to the researcher that the participant is experiencing significant distress during the study due to their participation as exhibited by emotional and psychological instability, the participant's participation in the study may be ended at the request of the researcher for the participant's welfare.

Your participation in this study is completely voluntary, giving you the right to withdraw from participation at your will.

Jessica Magallanes, M.A.

Principal Investigator

Clinical Psychology Doctoral Student

Pepperdine University, GSEP - West Los Angeles

██████████@gmail.com

APPENDIX E

Local Community Resources

24 Hour Suicide Prevention Hotline
1-800-273-TALK (8255)

24 Hour Crisis Intervention Hotline
1800-854-7771

Los Angeles Gay and Lesbian Center
Transgender Services
McDonald/Wright Building
1625 N. Schrader Blvd.
Los Angeles, CA 90028-6213
323-993-7400

Los Angeles Gender Center
1923 Westwood Boulevard Los Angeles, CA 90025
310-475-8880
staff@lagendercenter.com

Gender Wellness of Los Angeles
2035 Westwood Blvd. Suite 204
Los Angeles, CA 90025
info@genwell.org
310-441-0411

Pepperdine University Counseling Clinic
16830 Ventura Blvd., Ste 216
Encino, CA 91436
818-501-1678

6100 Center Dr.
Los Angeles, CA 90045
West Los Angeles, CA 90089
310-568-5752

APPENDIX F

Initial Screening Interview Questions

Script:

Hello (name of potential participant).

This is Jessica Magallanes, the researcher for the study *Going from “F” to “M” – Experiences with Formal and Informal Support*. I want to first thank you again for your interest in the participating in this study.

First I want to thank you again for your interest in being a participant in this study. This initial contact will serve as a screening to ensure that you meet requirements for participation in the study. I will also give you a chance to ask questions you might have about the study so you can make a decision about whether participation is right for you. If at the end it looks like you meet requirements and you decide you want to continue on to participation, we will schedule our first of three face-to-face interviews. The following questions, again, are only used for consideration of your participation in the study. All information provided in this questionnaire will remain confidential.

- 1. How did you find out about this study?

- 2. What is your age? (at least 21 years of age required) _____

- 3. Do you identify as a female-to-male transgender individual. (yes required)

Yes	No
-----	----

- 4. How many years have you identified as a transgender person? _____

- 5. How long ago did you begin your transition from the female to male gender? _____
(required – within the past 10 years but no sooner than 3 years)

Page 1

- 6. Does your social network consist of other transgender persons? (yes required)

Yes	No
-----	----

- 7. Which of the following supportive services have you participated in within the time that you have identified as a transgender person?

Individual Counseling	Group Counseling	Psychiatric Services
Hormone Treatment	Peers Support Groups	Transgender Community Activism
Transgender Community Events	Other (list below)	

8. How long have you participated in supportive services? _____
(at least 3 years total as an adult required)

9. Did you participate in psychological counseling as a child or adolescent? (not required)

Yes No

If YES, how long did you participate in counseling? _____

10. Have you participated in psychological counseling as an adult?

Yes No

If YES, how long did you participate in counseling as an adult? _____
(at least 3 years total as an adult required)

Page 2

11. Are you currently participating and regularly attend individual psychological counseling?
(not required)

Yes No

12. Have you been free of significant or disabling anxiety for the past 30 days?
(Yes required)

Yes No

13. Have you been free of significant or disabling depression for the past 30 days?
(Yes required)

Yes No

14. Have you been free of any suicidal ideation for the past 30 days?
(Yes required)

Yes No

15. The study requires participation in three 90-minute face-to-face interviews that will be held at Pepperdine University's Counseling Clinic in West Los Angeles, and will be held on Mondays and Fridays. You will need to provide your own transportation to and from these interviews. Will you be able to do this?

Yes No

Now I want to first give you a chance to ask any questions you have about the study or about my work as a student at Pepperdine University. [Questions from Participant]

If the candidate meets requirements:

It seems that you meet all requirements of participation in this study. After speaking with me, do you wish to be the participant in this case study?

[If YES]

As indicated in the description included in the description of the study, participation in this study requires participation in three 90-minute face-to-face interviews. All interviews will be audio recorded, and will be conducted at the Counseling Clinic located at Pepperdine University's Graduate School of Education and Psychology, located in West Los Angeles. During the initial meeting we will review the Consent for Participation Form that will need to be signed by you, and then begin then officially begin the interview. These interviews will be held on Monday and Fridays, during regular business hours.

Page 3

[Schedule all three interviews and give address]

It will be also be important to be available for email contact following the interviews if needed during the writing process. This is to make sure that what is written accurately reflects your experience as much as possible. Is the email address where the screening material was sent the best way to contact you if needed for this purpose?

Lastly, although it is not a requirement for participation, journal/diary entries or letters that speak to your experience with support services as a Transman would likely help to tell your story. Would you be willing to share copies of any of these that you might have for the purpose of additional information for the study?

[Closing]

Thank you again for your interest in this study. If you need to contact me prior to our meeting for any reason please feel free to email me. I will see you on [scheduled appointment time].

Have a great day.

Page 4

APPENDIX G

Informed Consent

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH STUDY

Participant: _____

Principal Investigator: _____
Jessica Magallanes, M.A.

Title of Project: _____
Experiences with Formal and Informal Support: A Case Study of a Female-to-Male Transgender Individual

I _____, agree to participate in the research study being conducted by Jessica Magallanes, M.A., a doctoral student at Pepperdine University, Graduate School of Education and Psychology, and under the direction of Dr. Shelly Harrell, Ph.D., faculty at Pepperdine University, Graduate School of Education and Psychology.

The overall purpose of this research case study is to gain an in-depth retrospective account of the journey through experiences in both formal and information supportive services while transitioning from the female to male gender. The use in-depth personal interviews will allow for greater information and detailed accounts of the experience of seeking and receiving supportive services as a transgender person. Interviews will gather information regarding individual background and history, especially as it pertains to the decision to participate in supportive services, how services have been experienced, and the usefulness of these services.

My participation will involve engaging in semi-structured in-depth interviews one-on one with the researcher which will be audio recorded. The first interview will gather information about pertinent historical, familial, psychological, medical, and cultural background data. Subsequent interviews will be steered specifically towards detailed accounts of experiences in supportive services (e.g., psychological counseling, support groups), and reflection on these experiences. I am also aware that I may be asked by the researcher to provide personal materials that speak to my experience of supportive services (i.e., journals, diaries, letters, etc.). **However**, I understand that providing such materials are not required for participation in this study, and that I have the right to decline a request to provide the researcher with any such materials.

My participation in the study will require a commitment of three 90-minute face-to-face interviews, as well as some e-mail contact with the researcher for clarification purposes during the writing process. I will be compensated for participation in the study in the form of a \$25 Visa gift card at the end of each face-to-face interview, and a \$50 Visa gift card at the end of my participation in the study. The face-to-face interviews shall be conducted at the Pepperdine University Clinic located in West Los Angeles on Mondays and/or Fridays during regular business hours.

I understand that while no other direct benefits are guaranteed, as a participant in this study I might gain knowledge about the impact of supportive services in my life. I understand that there may also be benefit to the transgender community or to professionals; to the extent the study produces knowledge or information that is useful to researchers or clinicians.

I understand that participation in this study poses no more than minimal risk comparable to that encountered in daily life or in routine psychological testing. I understand that there are certain risks and discomforts that might be associated with this research. These include some possible internal distress (i.e., temporary or fleeting feelings of sadness, frustration, or irritation) due to recollection of negative or difficult events, thoughts, or emotions that are discussed during the course of my participation in this study. If it becomes evident to the researcher that I am experiencing significant distress during the study

due to my participation, as exhibited by emotion and cognitive instability, I understand I will be encouraged to follow-up with the list of community counseling service referrals that will be provided at the beginning of the study, and/or that my participation in the study may be ended by the request of the researcher in order to prevent significant risks to my well-being.

I understand that I may choose not to participate in this research.

I understand that my participation is voluntary and that I may refuse to participate and/or withdraw my consent and discontinue participation in the project or activity at any time without penalty or loss of benefits to which I am otherwise entitled.

I understand that the investigator will take all reasonable measures to protect the confidentiality of my records and my identity will not be revealed in any publication that may result from this project. The confidentiality of my records will be maintained in accordance with applicable state and federal laws. Under California law, there are exceptions to confidentiality, including suspicion that a child, elder, or dependent adult is being abused, or if an individual discloses an intent to harm him/herself or others.

I understand that the investigator is willing to answer any inquiries I may have concerning the research herein described. I understand that if I have further questions, I may contact Shelly P. Harrell, Ph.D., at Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045, [REDACTED], [REDACTED]@pepperdine.edu. If I have further questions about my rights as a research participant, I may contact Doug Leigh, Ph.D., Chairperson of the Graduate and Professional Schools Institutional Review Board, Pepperdine University, Graduate School of Education and Psychology; 6100 Center Drive, Los Angeles, CA 90045, (310) 568-2389, doug.leigh@pepperdine.edu.

I understand to my satisfaction the information regarding participation in the research project. All my questions have been answered to my satisfaction. I have received a copy of this informed consent form which I have read and understand. I hereby consent to participate in the research described above.

Participant's Signature

Date

I have explained and defined in detail the research procedure in which the participant has consented to participate. Having explained this and answered any questions, I am cosigning this form and accepting this person's consent.

Principal Investigator's Signature

Date

APPENDIX H

Semi-Structured Interview Guide

General Information Rapport Building:

Can you talk to me about why you were interested in participating in this study?

Participation in this study means recalling, speaking about, and reflecting on your life time experiences, some pleasant and others not so pleasant. How are you feeling about giving details about your life and experiences?

Parents:

Tell me a little bit about who raised you. Who was in your family? Who took care of you?

What was your relationship like with your caregivers as you were growing up?

Have you come out as Trans to your caregivers? If yes, when? Why or why not?

Describe the experience of coming out to your caregivers.

Did coming out change the relationship? How?

Describe your current relationship with your caregivers.

Siblings:

Do you have any siblings?

(If yes):

How many siblings? How many sisters/brothers?

How would you describe your siblings as people?

What was your relationship like with your siblings as you were growing up?

Have you come out as Trans to your siblings? If yes when? Why or why not?

Describe the experience of coming out to your siblings.

Did coming out change the relationship? How?

Describe your current relationship with your siblings.

(If no):

What was it like being an only child?

Yourself/Development:

Describe yourself as child.

Describe your gender development:

When did you first begin to recognize feelings of discrepancy between your sex and your gender?

Can you describe your understanding of gender and biological sex as you were growing up?

Did you (or others) notice differences between yourself and females your age? Can you describe their reactions? How did you handle/deal with these reactions?

Did your parents/siblings notice differences between yourself and females your age? Can you describe their reactions? How did you handle/deal with these reactions?

How did you handle/cope with feelings of gender/sex mismatch?

Relationships:

What is your identified sexual orientation?

Describe when you first started having romantic feelings for others. (Who was your first crush?)

When did you start dating? Describe that experience.

Describe/discuss significant relationships.

What impact has being Trans had/have on your social/romantic/familial relationships? (Before and after coming out)

Education/Work:

What type of school did you go to? (Public/Private/Religious affiliation?)

What's your highest level of education?

Did you get along with schoolmates/instructors?

Describe any experiences of bullying or teasing from either other students or adults.

Describe your overall school experience.

Describe your first employment experience?

What has been your experience looking for/maintaining employment as a Transman?

What has been your overall experience working as a Transman?

How different is your experience of working as a Transman vs. working as a female?

Ethnicity/Culture & Religion:

What is your ethnic background?

What role did your ethnic/cultural background play in your personal development?

Describe the impact of your ethnic cultural background on your experiences as a Transman.

Did you ascribe to or identify with any religious/spiritual beliefs as a child?

What role did religion play in your personal development?

Describe your current religious/spiritual beliefs.

What role do your religious/spiritual beliefs play in your current life?

Describe the family culture you grew up in and role it played on your personal development.

Describe the culture the town/city you grew up in and its impact on your personal development.

How has your culture (ethnicity/religious beliefs/familial and environmental) impacted your experiences of formal and informal support?

Coming out:

Describe your decision to come out as a Transman. When? Who did you come out to first?

Describe your experience of coming out as a Transman.

What helped you cope with difficulties when coming out? Type of support utilized?

Supportive Services:

Describe the types of support you have utilized.

What factors went into your decision to seek out supportive services as an adult?

Why types of services did you initially seek out and why?

What issues were you looking to seek help for?

Describe the process of seeking support (Difficulty or ease; availability of services for transgender community; barriers to services; etc.)

What role has formal and informal support played your decisions around transition?

Describe the role of support in your development specifically as a Transman.

Describe the role of support in your development generally as a person.

Describe positive experiences of support and what you believe made them so.

Describe negative experiences of support and what you believe made them so.

Describe experiences with therapists/facilitators of supportive services and what impacted these experiences. (Personal reactions to therapist/facilitator; therapist/facilitator's characteristics, etc.)

Looking back on your experiences of formal and informal supportive, what do you know now that you wished you had known back then?

What improvements do you think can be made to supportive services?

APPENDIX I

NIH Certificate of Completion



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Jessica Magallanes** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 04/11/2010

Certification Number: 392218

APPENDIX J

GPS IRB Approval Notice

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

July 22, 2013

Jessica Magallanes

Protocol #: P0413D15

Project Title: Experiences With Formal And Informal Support: A Case Study of a Female-To-Male Transgender Individual

Dear Ms. Magallanes:

Thank you for submitting your application, *Experiences With Formal And Informal Support: A Case Study of a Female-To-Male Transgender Individual*, for expedited review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your advisor, Dr. Shelly Harrell, completed on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 (Research Category 7) of the federal Protection of Human Subjects Act, the IRB conducted an expedited review of your application materials.

I am pleased to inform you that the application for your study was granted **Approval**. The IRB approval begins today, **July 22, 2013**, and terminates on **July 21, 2014**.

Your final recruitment documents and consent form have been stamped by the IRB to indicate the expiration date of study approval. One copy of the recruitment documents and consent form is enclosed with this letter and one copy will be retained for our records. **You can only use copies of the consent form that has been stamped with the GPS IRB expiration date to obtain consent from your participants.**

Please note that your research must be conducted according to the proposal that was submitted to the GPS IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For **any** proposed changes in your research protocol, please submit a Request for Modification form to the GPS IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and require submission of a new IRB application or other materials to the GPS IRB. If contact with subjects will extend beyond **July 22, 2014**, a **Continuation or Completion of Review Form** must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details

regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to “policy material” at <http://www.pepperdine.edu/irb/graduate/>).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact the GPS IRB office at gpsirb@pepperdine.edu. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,



Doug Leigh, Ph.D.
Chair, Graduate and Professional Schools IRB
Pepperdine University

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Ms. Alexandra Roosa, Director Research and Sponsored Programs
Dr. Shelly Harrell, Graduate School of Education and Psychology

