

TOWSON UNIVERSITY
COLLEGE OF GRADUATE STUDIES AND RESEARCH

TALKING GENDER: GENDERED LANGUAGE EXPERIENCES OF TRANS*
INDIVIDUALS WITH MEDICAL PROVIDERS

By

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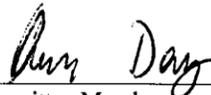
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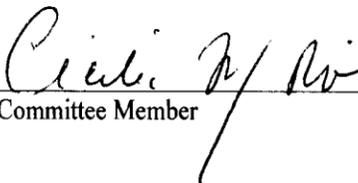
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ABSTRACT

D. Brienne Hagen

Gendered language can impact the way in which trans* individuals in the United States experience the healthcare they receive. This thesis highlights the experiences of trans* individuals with the gendered language used by their medical providers. A total of twenty individual interviews were conducted with trans* identified individuals. A thematic analysis was used to analyze participants' responses. Three primary themes emerged through the research: 1) the impact of medical forms in shaping the interactions with medical providers for trans* individuals, 2) the importance of Whole Person, Well Being care, and 3) the role of Misogyny and Privilege in shaping the experiences of trans* individuals. Recommendations for medical providers were created based on participants' responses. The concluding recommendations were direct communication, expanding forms, and creating healthcare focused on right care over right speech.

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CHAPTER ONE: INTRODUCTION

Trans* Healthcare

The visit with a new doctor can be an inherently stressful situation for most individuals. The financial costs, insurance coverage, embarrassing conversations, and the potential for possible challenges in regards to one's health can make doctors' offices a place that bring about dread for those sitting amongst the magazines of waiting rooms. Upon their first visit, individuals expect to have to complete some type of medical forms to make it through the waiting room and into the doctor's office where they will discuss their medical history, at least briefly, with their new doctor. While often stressful for many individuals, the doctor's office routine can pose unique challenges and create an uncomfortable environment for trans*¹ individuals. For trans* individuals, the discussion of gender identity, medical history, and the body can all be difficult subjects even with close friends and family, let alone medical professionals. These situations are often exacerbated by the fact that most healthcare providers do not have knowledge of trans* identities or health concerns (Rondahl, 2009).

Historically the medical and scientific communities in the United States have pathologized trans* patients which has contributed to a list of barriers to care for trans* patients, primarily revolving around the lack of education of trans* identities, transphobic

¹ In this research the word trans* will be used instead of the more common umbrella term, *transgender*. As this research will show, language can have the power to validate and invalidate identities and experiences. The language used in this research has been carefully chosen to be as respectful and inclusive as possible to individuals who identify along a transgender/transsexual/gender queer spectrum. While transgender has been used as an umbrella term, many gender non-conforming individuals do not identify under it. The word trans* has been chosen as more inclusive and open to the different identities of *transgender* individuals. The use of the prefix trans as its own independent word allows for the word to be open, inclusive, and reflect the movement within various trans* identities (Cromwell 1999, 26; Stryker 2008, 13).

prejudices, and gendered language (Sanchez et al, 2009). Often trans* individuals avoid professional medical care due to service providers' expected lack of knowledge and the pathologizing of trans* identities by the medical community (Schilder, Kennedy, Goldstone, Ogden, Hogg, and O'Shaughnessy, 2001; Serano, 2007). Finding medical providers has become a large challenge for trans* individuals who have to consider not only the provider's willingness to treat them but also the provider's respectfulness of their identity (Lombardi, 2001).

The concerns of trans* individuals vary greatly, as do the concerns of all individuals, in regards to what they want from their medical providers. Many trans* individuals may choose to pursue a variety of different types of medical transitions and will want a doctor who is knowledgeable, or at least willing to learn, about trans* identities and their care to assist them through the process. However, many trans* individuals will never choose to undergo any form of medical transition and will not need their doctors to have transition-specific knowledge. What is universal in the healthcare needs of trans* individuals is the need to be treated with respect, to feel safe, and to feel like they have a voice in their healthcare decisions. These needs can be applied to almost all individuals, and in many ways come down to what are often considered very basic individual needs. While these needs may appear to be basic or a given, for many marginalized and underrepresented groups these needs are rarely met through the healthcare they receive (Alegria, 2010). For trans* individuals in the United States finding a doctor, gynecologist, dermatologist, emergency care provider, cardiologist, or any other provider who will actually serve their healthcare needs is extremely difficult and results in a huge burden placed on trans* individuals' to go out of their way to research and seek out providers.

The lack of medical education and research on the health needs of trans* individuals contributes to creating an inhospitable climate for trans* persons to seek care. One reason for the difficulty in conducting research on the health concerns of trans* individuals is that there is no consensus or statistical information on the number of individuals who identify as trans*. This lack of statistical information is due to a number of factors. First, capturing the number of individuals who identify as trans* is extremely difficult since it is a self defined identity that would require self disclosure in order to measure. Second, the discrimination and stigmatization of trans* individuals has contributed to a climate in which disclosure of trans* identities has led to negative impacts². The large invisibility and marginalization of trans* people and identities within hegemonic American society perpetuates the absence of trans* persons from traditional medical studies and education. The lack of knowledge of trans* individuals needs and relates directly to the quality of care they receive.

Healthcare barriers for trans* individuals, such as lack of provider education, have led many trans* individuals to potentially dangerous situations by receiving pharmaceutical drugs, hormones, and transition related surgery from non-licensed individuals or street dealers (Lombardi, 2001). While finding health services creates a great barrier for trans* individuals, once inside the doctor's office there are new sets of challenges to overcome. What may be considered minor inconveniences for many cisgender³ individuals, such as completing new patient paper work or discussing medical history, can be significantly

² Trans* individuals experience extremely high rates of discrimination and marginalization. Bullying, loss of employment, harassment, loss of friends and family, physical and sexual violence, and homelessness are just some of the ways in which trans* individuals experience the harmful effects of others knowing their trans* identity (Grant et al, 2011).

³ Cisgender is a term used to describe non-trans* individuals. The use of the word cisgender challenges normative gender identity that is assumed when one says "man" or "woman" without a qualifier. (Stryker 2008, 22)

uncomfortable, scary, or triggering⁴ for many trans* individuals. Conversations about medical history provide just one example of the possible ways in which trans* individuals can face reminders of their socially constructed non-normative status. The gendered language used within medical settings by providers may not be congruent with their trans* patient's identity, adding to the discomfort and stress of this already strained relationship.

Identity disclosure can be difficult for many trans* individuals, regardless of who is on the other end of the conversation. Combining the uncomfortable conversation with the tumultuous relationship between trans* individuals and the medical community, poses unique challenges for trans* individuals. The importance of good and clear communication between patients and providers in improving the care received by patients has been a topic of research and discourse (Weatherall, 2002). However, the impact of patient/provider language has not been examined in regards to the needs and experiences of trans* individuals.

Gendered Language and Trans* Healthcare

Feminists have long argued that gender pervades all aspects of society. It affects our social roles, our dress, our relationships, our sex, our legal rights, our health, and our language. While there are specific lexical items we associate most often or directly with gender, such as woman and man, gender plays into all aspects of language and discourse. Gender is specifically impactful in the language that has been constructed and used in reference to the body. Dean Spade (2011) argues that the use of terms such as

⁴ The word triggering is being used within the context of this research to reference an event, word, image, or situation that can bring about a sudden great deal of stress, depression, or panic for an individual. For this paper, a trigger will be defined as anything that can spark an intense negative reaction. One example of this usage would be if a trans* individual were to begin to feel a great deal of anxiety and body dysphoria after seeing an image of a naked body, the image could be considered a trigger.

“biologically female,” “male-bodied,” or “female reproductive organs,” maintains an oppressive system of belief in what bodies should contain and look like. These terms become explicitly powerful for trans* individuals who are often referred to as “born female” or “born male” which maintains the assumption of the importance of the bodies and their construction (Spade, 2011). Such gendered body terms work to separate the individual’s identity from the body (Martin, 1987). The language used by medical providers when speaking with trans* individuals works to maintain disembodiment of identity and establish trans* identities as illegitimate in the eyes of the medical establishment that views their bodies as the reality.

Language serves as a tool to reinforce gender based oppression and stereotypes not only through words and their gendered specific connotations, but through the ways in which words are used to construct discourse (Eckert & McConnell-Finet, 2003).

Language is one of the primary ways in which society constructs what we know; it is a key to the creation of knowledge and power (Weatherall, 2002). The gendered language surrounding the body has been constructed through a historically patriarchal medical and scientific gaze. The construction of this language has been used to normalize bodies and other those who transgress such norms. While individuals may gain knowledge through what they see, it is the discourse surrounding what they see that truly shapes their experience and perception of it. For example, you may have a friend you work with who you have always known as a woman; she adheres to your perception of what a woman looks like and follows prescribed feminine gender roles. One day in talking with her she comes out to you as trans* and says that she was assigned male at birth; you then begin using male pronouns to refer to her and stop seeing her as a woman, not because she has

changed but because the language that has enforced how you view gender and bodies places value on what you assume her body to be.

Dean Spade argues that medical providers must be aware of the gendered aspects within the language they use and the ways it can reinforce gendered oppression and stereotypes. The use of terms like “male-bodied” maintains the belief that there is one naturally defined body for men, one that is separate from identity and personhood. Use of such language can create uncomfortable alienating environments for trans* individuals to seek and receive medical care.

With gender so deeply woven to language, defining what specifically gendered language is can be difficult. Regardless of whether an individual specifically intends for the words they use to carry a gendered meaning, gender will continue to play a role in their linguistic interactions with others. The pervasiveness of gendered language in the interactions between medical providers and cisgender women has been problematized by many feminist scholars and activists in regards to the role language plays in cisgender women’s reported satisfaction with their providers in the United States (Laurence & Weinhouse, 1994). In the relatively few studies that focus on the concerns of cisgender women or trans* individuals medical care, cisgender women and trans* individuals have reported experiencing gender based discrimination from their providers to the point where they had to find a new provider (Laurence & Weinhouse, 1994; Lombardi, 2001). The role that gendered language plays specifically in the care experienced by trans* individuals has not previously been examined.

Whether it is the language used in conversations between medical providers and trans* individuals or the language on medical forms, gendered language can create

conflict for trans* individuals and compromise quality of care (GLBT Health Access Project, 2000). To better understand trans* experience in context of medical care, examinations of gendered language as it shapes conversations between trans* individuals and their medical providers is needed to improve the quality of health care experienced by trans* individuals. It is vital to understand how gender is perceived, interpreted, and used through language between trans* individuals and their medical providers in order to see the potential positive or negative impacts of gendered language on trans* healthcare.

Present Study

It is not the intention of the present study to argue that gendered language is wrong, inherently problematic, or that we should fight for gender blind language. Gendered language is absolutely important and necessary in many aspects of society. Gendered language can affirm someone's gender identity, making gender a visible point of analysis, to be able to have the language to discuss gender based oppression, and the most evident reason, it is what individuals use to define themselves in terms of gender (Weatherall, 2002). Focusing on the way in which gender interacts with language can help reveal the ways in which gendered language has acted as a patriarchal tool and contributed to gender based oppression. Because of its varying possibilities for formulation, in this study gendered language will focus on and refer to any type of language (i.e. words, phrases, verbal interactions, verbal dynamics) that directly refers to gender, or carries gender related connotations within the context used.

While this study is strongly grounded in a theoretical framework and foundation, the focus and aim of the study is to address an issue of great importance to the lives of trans* individuals: health. Gendered language is merely one aspect in which trans* individuals

may experience an impact on the quality of healthcare they receive, along with multiple other factors such as lack of provider knowledge and refusal of services. Building upon the existing theory surrounding both gendered language and literature on trans* healthcare, I aim to present experiences of trans* individuals in the context of gendered language and medical providers in the United States. I use these experiences to propose recommended changes to improve the quality of care received by trans* individuals.

One fundamental aspect of this study is the intention to use feminist and queer theory in a way that can benefit trans* individuals. Trans* individuals have often been used as examples by feminist theorists in which to prove their theories or challenge gender essentialism or binaries (Butler, 1990). By coming from a within community perspective, this study aims to reverse the previous focus on using trans* identities to prove theory and instead apply theory to benefit trans* individuals.

This study was designed to allow trans* individuals' the agency to tell their own experiences, and to discover the ways in which patient/provider communication can be improved to better the health care trans* individuals receive. Throughout this research, the experiences of trans* individuals with medical service providers, specifically their experiences with gendered language, was considered. The research focuses on negative, positive, and neutral experiences with medical providers by the trans* individuals interviewed.

While trans* health care has long been determined and regulated by cisgender medical and psychological professionals, this study explores gendered language and health care from within community. My own identity as a trans* person is intrinsically important in my involvement and role as researcher. By openly identifying with the study participants

I was able to establish trust and build a connection with those I interviewed. My identity positions this study to be read in contrast to the long history of cisgender individuals speaking on behalf of trans* individuals, presenting instead through a trans* lens⁵. This is not to say that my own experiences or identity are comparable or relative to the experiences of all trans* individuals, or even all participants. However, in discussing my identity with participants I explained my desire to perform research from within the larger community and work to improve trans* healthcare experiences. In conversations with participants, I did not experience my identity as having a negative or alienating effect on any of the participants. I did find that participants who identified as genderqueer or were in their thirties or younger were more likely to ask me questions about my identity and experiences. This increased interest or desire for further communication by certain participants may have been related to my identity or by what they perceived to be my age.

In chapters two and three I provide further background on the topics of trans* health care and gendered language, as well as explain my research design. In chapter two, Literature Review, I will establish the previous research and discourse relevant to gendered language and trans* healthcare. I discuss the many barriers faced by trans* individuals as they attempt to receive competent, quality health care; showcasing the various ways that discrimination has impacted the health of trans* persons. In chapter three, Methods, I explain my research method and provide some information about my

⁵ The emphasis in this statement of perspective is on the letter '*a*.' There is certainly no one trans* lens or perspective and this statement is not intended to imply that there is. Instead I am applying Standpoint Theory to explain my role as researcher and in my analysis, arguing that my own experiences and perspectives as a trans* person have shaped the lens in which I have viewed this research. While my own standpoint cannot be reflective of all trans* persons, or even all individuals interviewed, it does benefit the research by allowing the study to come from within the trans* community.

participants. Chapter four, Gendering Interactions Through Language, contains discussion of the experiences shared by those I interviewed regarding the importance of gendered language to their experience of health providers. I present the three themes that emerged during the interviews 1) the role of medical forms in shaping the patient/provider interactions, 2) the importance of Whole Person, Well Being, and 3) the effect of misogyny and privilege on trans* individual's experiences with providers. Finally, in chapter five, Conclusion and Recommendations, I end with recommendations of ways in which to mediate and eliminate the problems experienced by trans* individuals in the United States, as well as expanding upon their own recommendations and positive experiences.

CHAPTER TWO: LITERATURE REVIEW

Gendered Barriers to Healthcare

The subject of trans* healthcare has become an increasingly popular area of interest over the last two decades, as well as a shift in the overall framing of trans* care in the United States from a perspective that pathologized trans* persons to one that takes a more holistic approach (Algeria, 2011). In the past decade the medical and scientific community has begun to reexamine their treatment of trans* persons. Much of the new literature and attention coming from the medical community has focused around decreasing the barriers that prevent trans* persons from seeking, receiving, or maintaining care (Algeria, 2011; Sanchez, Sanchez, & Danoff, 2009).

Perhaps the largest barrier to trans* care is the overall lack of knowledge of trans* persons by healthcare providers (Sanchez et al, 2009). Education about trans* identities, concerns, and care are not usual topics covered in the curriculum of healthcare professionals and is often labeled as a specialty (Rondahl, 2009). Despite gradual improvements in the increase of trans* education for medical providers, a 2009 study of nursing students found that only 10% had a basic knowledge, of LGBT⁶ terminology and identities (Rondahl, 2009). This knowledge gap works to create an environment in which trans* patients are often expected to have to educate their doctors about their trans* identity, which can become a deterrent for trans* patients to seek care (Gay/Bi/Queer Trans men Working Group). The recent study *Injustice at Every Turn* conducted by the National Center for Transgender Equality and The National Gay and Lesbian Taskforce

⁶ LGBT is an acronym for Lesbian, Gay, Bisexual, and Transgender

including the responses of 6,456 trans* participants from across the United States, found that 50% of trans* individuals interviewed reported having to take the time to educate their doctors about trans* identities (Grant et al 2011, p.72). Placing the responsibility on trans* individuals to educate their providers takes the focus and time away from providing them care during their appointments and can impact the care they receive (Gay/Bi/Queer Trans men Working Group).

The invisibility within medical research has led to a lack of medical provider education and knowledge in the area of trans* patients and can be seen as directly related to the care they receive. Leslie Laurence and Beth Weinhouse (1994) have addressed the lack of medical research regarding the specific concerns of people assigned female at birth and argue that until the early 1990s people assigned female were rarely if ever, included in medical studies. They argue the lack of inclusion in medical studies directly relates to inadequate and “second-class healthcare” (Laurence & Weinhouse 1994, p. 22). Similarly, while trans* individuals are devastatingly understudied and missing from medical education, transmasculine individuals in particular have historically been an overwhelmingly underrepresented, understudied population (Forshee, 2008). No large scale medical studies have included transmasculine populations to date and very little research has focused on the overall medical needs of transmasculine individuals (Forshee, 2008). Despite insufficient provider knowledge, many trans* persons have experienced their medical providers becoming upset or angry with them when they appear to have knowledge about trans* health that their providers do not (GLBT Health Access Project, 2000). The majority of trans* individuals have experienced a lack of medical provider knowledge related to either their trans* identity, providing adequate healthcare for all of

their needs, or providing trans* related healthcare (i.e. hormone therapy, effects of hormone therapy, surgical options, etc) (Grant et al, 2011).

Without education about trans* identities and concerns, providers are not only taking time away from their patients, but using language and making statements that are offensive and can create uncomfortable environments for their patients. Because providers lack the knowledge to adequately treat trans* patients, many trans* individuals are forced to delay care for months and sometimes years before obtaining accurate diagnosis and appropriate treatment (Dutton & Fennie, 2008). This delay may cause their symptoms and problems to worsen.

Transphobia and discrimination. Discrimination that trans* individuals experience due to transphobia⁷ can take explicit and implicit forms. Another large barrier for trans* patients has come from the historical biases and prejudices that have been experienced and seen towards trans* identities from medical providers (Rondahl, 2009). The concern over whether or not a doctor could be considered trans* friendly is vital for many trans* persons in deciding to seek or stay with medical care. Understandably, a trans* person may avoid going to any healthcare provider who displayed an overt bias towards trans* identities. Despite society's growing (very slowly growing) acceptance of trans* persons, many trans* individuals still experience prejudices from their medical providers, which can cause them to discontinue or not seek future medical care (Samuel & Zaritsky, 2008; Schilder et al, 2001).

Many trans* individuals have experienced overt discrimination from medical providers that has prevented them from receiving health related care (Grant et al, 2011;

⁷Transphobia is defined as the "irrational fear of, aversion to, or discrimination against people who transgress gender norms" (Serano 2007, p.12)

Dutton & Fennie, 2008; Gorton, Buth, & Spade, 2005; Newfield et al, 2006). The study *Injustice at Every Turn* found alarmingly high rates of discrimination within healthcare settings for trans* individuals (Grant et al, 2011). The study found 24% of trans* respondents experienced unequal treatment because of their gender identity in doctor's offices and hospitals, 5% by emergency medical technicians, and 3% in emergency rooms (Grant et al 2011). In the same study, 28% of trans* participants had experienced verbal harassment in a providers office, while 2% had been physically assaulted in a medical setting (Grant et al 2011). Medical treatment was refused completely for 19% of respondents (Grant et al, 2011). Throughout the survey, the intersection of racism with transphobia greatly increased the rates of discrimination experienced by trans* individuals of color. Respondents also reported higher rates of discrimination if their providers were aware of their trans* identity (Grant et al, 2011). These statistics are extremely helpful in painting a portrait of trans* health care experience that, until this study, has largely been unrecorded. The study helps to document the severe issue of discrimination facing trans* persons' access to quality health care and the need to improve trans* health care.

Prior experiences of prejudice including verbal harassment, refusal of services, refusal to acknowledge gender identity, or unequal treatment, as well as knowing another trans* individual who has experienced such discriminatory treatment causes many trans* individuals to avoid seeking medical care when it is needed (Grant et al, 2011; Dutton & Fennie, 2008; Gorton, Buth, & Spade, 2005; Newfield et al, 2006). Even when individuals do not wish to delay their care, they are often forced to delay care they need as they search for trans* friendly providers. Delaying medical care can have dire

consequences for an individual's health, which may or may not be reversible. One well known case of discrimination and refusal of care of a trans* individual is the case of transmasculine individual Robert Eads, whose story is chronicled in the documentary *Southern Comfort*. Eads was refused medical treatment for ovarian cancer by numerous medical providers because of his transgender identity, which resulted in his passing away from the illness.

Medical bias is not always overt or in person but can also be seen in the way in which trans* persons are discussed in medical literature. The medical community has at times portrayed trans* patients as liars who intend to deceive healthcare providers (Serano, 2007). This lack of trust of trans* patients can be seen in the title of the article by J. Michael Bailey (2007), *What Many Transgender Activists Don't Want You to Know: And Why You Should Know it Anyway*. The title of the article alone, even before addressing the content of the article which will be examined later, showcases the distrust of the medical community of trans* patients as it portrays trans* activists as hiding truths from doctors, creating an "Us v. Them" mentality.

Pathologizing trans* identities. Historically trans* identities have been shaped and regulated by the science and medical communities (Stryker, 2008; Serano, 2007). Like the identities of lesbian, gay, bisexual, and queer individuals, labels and categories for trans* identities have often been created and defined largely by the voices of cisgender individuals using the guise of science to hide their own bias (Stryker, 2008). The medical construction of the transsexual and other trans* identities was forged by biases and prejudices that are similar to the studies that were done that attempted to "prove" the belief in the superiority of white people and men that used "science" to hide their bigoted

beliefs (Stryker 2008, 36). Trans* related care was largely taken control of by the psychological community. The psychological framework labeled trans* identities as abnormal, with the medical focus on curing or fixing trans* individuals (Serano, 2007).

The majority of trans* care has been shaped by Harry Benjamin and his Standards of Care (Serano, 2007). Harry Benjamin began working with MTF⁸ trans* persons in the 1920s and became a predominant voice in their treatment. Almost all of the early work and attention given by the medical and scientific communities to trans* individuals surrounded MTF individuals, leaving FTM⁹ individuals largely invisible (Serano, 2007). Benjamin went on to create the Standards of Care which until recently, acted as the guidelines for psychologists in working with trans* persons (Serano, 2007). The Standards of Care dictated that in order for a trans* person to receive hormone

⁸ The term MTF stands for Male to Female. The term has been used to describe individuals who were assigned male at birth and whose transition has moved toward a female or feminine identity. There is much debate over the use of the term where many individuals find the term to be offensive while others identify with the term. Many individuals do not identify with the term because they do not identify as ever having been male, others do not like the term as it carries with it the word male despite the individual's gender identity, while others hold strongly to the term as their primary identity. The use of the term MTF appears here in reference to the way individuals are spoken about and classified within the medical literature. The term will not be used throughout the course of this research study and writing unless specifically referring to how an interview participant identifies or in reference to medical literature that uses such language. The researcher will not use this term to identify any individual unless the individual claims it as part of their own identity.

⁹ The term FTM stands for Female to Male. The term has been used to describe transgender individuals who were assigned female at birth and whose transition has moved toward a male or masculine identity (Cromwell 1999, 28). The term has become a less popular today and is often one that brings about great debate. Many individuals do not identify with the term because they do not identify as ever having been female, others do not like the term as it carries with it the word female despite the individual's gender identity, while others hold strongly to the term as their primary identity. The use of the term FTM appears here in reference to the way individuals are spoken about and classified within the medical literature. The term will not be used throughout the course of this research study and writing unless specifically referring to how an interview participant identifies or in reference to medical literature that uses such language. The researcher will not use this term to identify any individual unless the individual claims it as part of their own identity.

therapy¹⁰ they would need to be seen by a psychologist for a minimum of three months, afterwards they would be expected to perform a “Real Life Test” that involved the patient to live as their identified gender fulltime for a designated period of time until the psychologist deemed them to have “passed” the test and would recommend for them to receive hormone therapy (Serano, 2007). While the Standards of Care are still the most renown and used guidelines for trans* care, many healthcare providers have begun using other methods of treatment, such as Informed Consent which allows trans* patients to receive hormone treatment without therapy by signing consent forms stating that they are aware of the effects of the medication and agree to the treatment.

While informed consent forms may appear to be moving in a direction toward providing trans* patients with agency over their healthcare, trans* identities are still heavily pathologized by the diagnosis of so called Gender Identity Disorder (GID) in the Diagnostic & Statistical Manual of Mental Disorders (DSM IV). A patient can be labeled as having GID if they meet the criteria of experiencing distress due to incongruence between their assigned sex at birth and their own gender/sex identity. The existence of GID in the DSM has helped keep many trans* persons, who do not desire for their identity to be labeled as a disorder, from seeking mental health therapy (Stryker, 2008).

Medical care guidelines such as the Standards of Care and GID have been used to allow medical and scientific communities to regulate and control gender at large. The framing of trans* identities as a disorder has implied that trans* identities are something

¹⁰ For trans* individuals, hormone replacement therapy is the most popular transition related medical treatment. For individuals assigned female at birth who identify along a masculine spectrum, the most common form of hormone therapy is testosterone therapy. The most popular methods of testosterone therapy involve the individual taking doses of testosterone through injection or external application of a gel or cream. For individuals assigned male at birth who identify along a feminine spectrum, the most common hormone therapy involves the use of estrogen injections, pills, or external creams and gels.

that can be fixed or corrected to a normalized gender identity, which helps to maintain a binary gender system. Susan Stryker (2008) has argued that the increased scrutiny of trans* identities has formed itself alongside a conservative response to feminist progress over the past half a century. She explains that medical communities have attempted to stifle trans* identities from self expression as a means to maintain the gender oppressive structure that feminism has been working to eliminate (Stryker, 2008). Psychologists have practiced gender regulation in their trans* patients for decades under the Standards of Care by forcing their patients to adhere to traditional binary gender roles and identities (Serano, 2007). Julia Serano (2007) has noted that in order for trans* patients (primarily trans women¹¹) to pass through the Standards of Care guidelines to acquire hormone treatment, they must portray the epitome of the gender in which they identify, a standard that is not as equally practiced amongst cisgender individuals. For many trans* patients, to meet this ideal has historically meant to create a gender façade in which to show the therapist (Serano, 2007). This gender façade often entailed dressing up for therapists and portraying a more binary gender identity than the individual may actually have. While trans* individuals were pushed into this gender performance by the gender regulation of the therapists, many medical professionals in the United States began to take notice and responded by framing trans* individuals as deceitful and liars (Serano, 2007).

Medical professionals have ignored the voices of trans* individuals and activists and have attempted to explain away trans* identities. Explanations for trans* identities are

¹¹ Trans women refers to individuals who were assigned male at birth who identify along as women or along a feminine spectrum (Serano, 2007). This is a gender identity and therefore should only be applied to individuals who identify as trans women. Not all trans* individuals who were assigned male at birth identity with the term trans woman or trans women. This term will only be used within this study in reference to the way individuals have specifically identified or in reference to the language used within previous literature.

popular amongst medical and psychological literature on trans* patients. These medical and psychological explanations for trans* identities are highly gendered, constructing different explanations for individuals who transition to a feminine identity compared to a masculine identity (Bailey, 2007). Trans* persons who identify along a FTM or masculine spectrum have had their identity claimed by medical professionals to be merely a response to the gender inequalities in our society and an attempt of these individuals to seek more resources, power, and respect as men (Lombardi, 2001). Trans* persons who identify as MTF or along a feminine spectrum have been highly sexualized by the medical community and society at large (Lombardi, 2001). These definitions and explanations created by the medical and scientific community have been used as a way to dismiss and regulate trans* identities (Cromwell, 1999).

The sexualized explanation for trans feminine individuals became popular largely through the work of Ray Blanchard and has continued through the work of J. Michael Bailey (2007). Bailey (2007) and Blanchard (1988; 1989) have argued that there are two types of MTF trans* persons, the first type is what they refer to as homosexual¹² and the other being non-homosexual/autogynephilia¹³. Bailey (2007) defines homosexual in this context as a reference to the individual's assigned sex and birth and not their gender identity. By identifying trans* individuals' sexuality based upon their assigned sex at birth, Bailey completely disrespects the individual's gender identity. He states that while

¹² Homosexual Transsexuals a term created originally by Ray Blanchard but has been used by J. Michael Bailey. The term is one of the two categories of MTF transsexuals that Blanchard and Bailey have constructed. Bailey and Blanchard believe that homosexual transsexuals are trans* identified because they are truly homosexual men who choose to transition to women because they perceive their lives would be easier if they were heterosexual and would be able to find male partners more easily (Bailey, 2007)

¹³ Autogynephilic Transsexuals is a term created originally by Ray Blanchard but has been used by J. Michael Bailey. The term is one of the two categories of MTF transsexuals that Blanchard and Bailey have constructed. Autogynephilic transsexuals are individuals who's trans* identity is claimed to come from an eroticized image of oneself as a woman and having sex as a woman (Bailey, 2007).

the use of the word homosexual and the two categories themselves are seen as offensive to the vast majority of individuals in which he classifies under them, he still believes they are the best words to use (Bailey, 2007). His blatant disregard for the language of trans* communities and individuals, shows the continued biases that exist within the medical community against trans* people. Trans* individuals are aware of the traditional medical attitudes towards trans* identities, making openly identifying with providers an often difficult aspect of seeking care.

Comfort and identity disclosure. The fear that many trans* persons have of experiencing discrimination by medical providers can deter conversations between trans* patients and their doctors regarding their gender identity (Lombardi, 2001). This concern over disclosure can be intensified by the lack of trans* knowledge and biases of medical professionals. For some trans* persons, disclosure may seem like nothing more than an obstacle to care and they will decide not to disclose with their providers (Davis, 2009). Many trans* persons choose to not disclose their gender identity to their providers, knowing it may mean they will have to educate their healthcare provider on trans* identities (Davis, 2009). Choosing not to disclose one's trans* identity can lead to the incorrect use of gendered language by healthcare providers. If a doctor is unaware of the gender identity of their trans-masculine patient, they may use feminine pronouns or make references to the patient as a woman which could cause the patient to feel uncomfortable or that their identity is being invalidated, even if it is not the intention of the doctor. This discomfort around discussing identities with medical providers poses the ability to create a barrier to care for many trans* patients (Sanchez et al, 2009).

Davis (2009) found, in a series of interviews with trans* persons in the United States, that many found their gender identity and presentation to be “negotiable” depending upon the environment they were in. The individuals she spoke with expressed that they were conscious of their gender presentation and were often cautious of displaying their gender identity in settings or around people that they were unsure of or unfamiliar with (Davis, 2009). For many trans* persons their doctor’s office may be a place in which they do not feel they will be accepted if they display their true gender identity, encouraging them to avoid disclosure. Davis (2009) also found that often times when trans* persons did disclose their trans* identity to a new person, how much they shared and how true the information was to their identity varied depending upon the setting. While many trans* identities are not contained within binary gender categories, our society at large exists within these categories causing some trans* persons to take on gendered labels, such as woman or man, that they do not truly identify with merely because they are easier for others to digest (Davis, 2009). This half disclosure can lead to medical providers using language that their patient may not be comfortable with, creating a barrier to care.

The Language Impact on Medical Care

The language doctors use in reference to, and in conversation, with their patients can improve or strain the relationship. In a study done at a Michigan health organization, more than 90% of the 1,000 complaints filed by patients showed their unhappiness with the care they received was due to communication problems (Laurence & Weinhouse 1994, p. 331). Even if trans* persons do find a provider they are comfortable seeing, they are likely to not return or continue care if they feel that their gender identity is not being respected (Lombardi, 2001). If a doctor does not use the correct pronouns of the patient,

does not refer to them as the gender or sex they identify as, or uses gendered terminology they are not comfortable with in reference to the patient's body they may feel that their gender identity is not being respected and is being invalidated. For many trans* persons, the feeling that a doctor is not being respectful of their gender identity will cause them to not only stop seeing the healthcare provider, but may impact their future decisions to seek medical care (Schilder et al, 2001).

Creating and choosing language that provides agency to trans* persons and reflects individual's identities in a respectful manner is a challenging task. Elizabeth Sarah Lindsey (2005) discusses the difficulty she faced in writing the chapter on sexuality and gender identity for the 2005 edition of *Our Bodies, Our Selves*. She describes the struggle of being aware of the privilege that language carries and that individuals should have the right to choose and create their own labels (Lindsey, 2005). Jason Cromwell (1999) agrees with the importance of in-community based language and states that using this language is not only more inclusive and respectful of identities but can also be empowering for the members of the community. He goes on to echo the fact that most of the predominant language used to identify and describe trans* people have been created by doctors and medical professionals and have not always been claimed by trans* communities (Cromwell, 1999).

One example of an in-community based health resource is the guide *Primed*, which was created by the Gay/Bi/Queer Trans Men Working Group in Ontario, Canada. *Primed* is a community based healthcare guide about safer sex and sexual related care for trans masculine identified individuals. The authors of the guide express the need to create educational materials and references for trans men since many do not seek professional

medical care. The guide reflects the importance of within-community based education and language; it also showcases concern over the language that was chosen for the guide in order to be as inclusive and affirming as possible. Like Lindsey (2005), the authors of the guide describe their struggle with finding language that is as inclusive as possible. The authors acknowledge that there is no language regarding trans* that every person will find inclusive, but that words can be chosen that are as inclusive and respectful of possible of varying identities. The guide states that language is not static and will change constantly over time, what may seem inclusive now may not seem inclusive five years from now. The evolution of language requires a constant dialogue to be made around languages uses and implications (Gay/Bi/Queer Trans Men Working Group).

For most doctor visits the interaction with gendered language comes early in the form of medical forms that must be completed before the exam or treatment. On these forms there will almost always be a question that asks a person's sex or gender, usually providing only two options in which to choose. The use of the word sex¹⁴ has been the more popular option overtime but is being used less today with the most preferred word being gender¹⁵ (Overall, 2007). These words themselves are problematic for many trans* individuals in regards to respecting their own identity, but also provide healthcare

¹⁴ Sex can be defined as biological or physiological. Sex categories involve classifying bodies based upon physiological factors, such as hormones, chromosomes, reproductive organs, and external genitalia. While sex appears to be straight forward, like gender, sex categories are socially constructed. While individuals' sex is usually defined within a male or female binary, biologists have shown that there is natural variation between sex characteristics and that many or most bodies cannot neatly be labeled as either male or female (Lorber, 1996).

¹⁵ Gender can be defined as a category surmising a variety of social interactions and identities. An individual's relationship to the sexed body, gender identity, social and family roles, and personality structure are all contributing factors to categorizing an individual's gender. How these different factors play into gender can also be affected by race and class (Lorber, 1996).

providers with the ability to make assumptions about their identity, medical history, and body.

Joan Roughgarden (2004) argues that these assumptions based on sex are misguided. She states that biologists are agreeing more and more that the sex cannot be seen as “unproblematically binary” (Roughgarden 2004, 288). Roughgarden (2004) believes that the medical community is to blame for continuing the societal mis-belief in a male-female binary and express the need for medical providers to begin seeing past a two option system and embrace the often fluidness of our bodies. She argues that this change would not only improve care for trans* patients but would improve medical care for all individuals if doctors stop assuming what makes up a person’s body by their exterior genitalia (Roughgarden, 2004).

For many individuals assigned female at birth, seeking gynecological care in a comfortable environment can be difficult due to the gendered language surrounding reproductive health. Language that surrounds “women’s reproductive health,” aside from being directly gendered, often centers around feminine empowerment and agency. While this approach is successful and beneficial for women identified individuals, it can create an environment that excludes transmasculine and genderqueer individuals assigned female at birth, consciously or otherwise. Many trans* individuals assigned female at birth experience and struggle with a great amount of body dysphoria where they may feel disconnected from their body, self conscious, insecure, or betrayed because they see their body as feminine, womanly, or it has been gendered by others in such a way. Entering into a space targeted towards women can inflate these issues for some trans* individuals, which can discourage them from seeking the medical care they need (GLBT Health

Access Project, 2000). Even for trans* individuals assigned female at birth who do not feel a great deal of body dysphoria and are otherwise comfortable with their body, can feel their gender identity may not be respected or validated within the gendered space of medical providers' offices (GLBT Health Access Project, 2000).

Gender's place in language is not always distinctly clear through lexical items like "woman" or "male," but is deeply woven into the ways in which individuals communicate in many subtle ways (Eckert & McConnell-Ginet, 2003). Connotations of words wield strong gendered relationships even when two words share almost identical definitions; the way in which society has constructed their use is gendered. The terms handsome and pretty are prime examples of words with like meanings but gendered connotations and applications (Eckert & McConnell-Ginet, 2003). The words a medical provider uses with their patients can impact their experience of the care they are receiving even if the provider is not aware of their words' gendered meanings.

The use of gendered language between trans* individuals and their medical providers serves as what Eckert and McConnell-Ginet (2003) refer to as a community of practice; in which the way individuals use and interact with language is specific to the pre-determined situation and relationship established. In order to examine any type of gendered language effect, the community of practice in which the language is taking place must be examined specifically, as the way individuals use language changes consistently throughout the day based on the individuals and situations in which they interact (Eckert & McConnell-Ginet, 2003).

CHAPTER THREE: RESEARCH DESIGN AND METHOD

The historically tumultuous nature of the relationship between trans* individuals and the medical community can be increased or eased by the use of gendered language. Whether it is the language used in conversation between medical providers and trans* patients or the language of medical forms, gendered language can create conflict or an inclusive space for trans* individuals; impacting the quality of care. Since much of medical conversation centers around the body, the use of gendered language poses the possibility of affecting the way in which trans* individuals interact or think about their body.

This research explores the experiences of trans* individuals in regards to the gendered language used in their interactions with medical providers in the United States. The research is intended to focus on gendered language as one specific element that impacts trans* healthcare through which the study of and future improvements could result in improving the quality of healthcare received and experienced by trans* individuals.

There has been little previous research done on the healthcare needs and experiences of trans* individuals. The research that has been conducted has disproportionately represented transfeminine populations, with transmasculine populations only beginning to become a focus of, or even a part of, health related research with the last decade. Studies that have been done on trans* healthcare have also largely focused on using trans* individuals as subjects for a larger goal of the researcher, but have not been used as a means to improve the overall access, quality, and experience of healthcare for trans* individuals. Previous research that has been conducted on trans* individuals' experiences

of healthcare have not explored the topic of language and its affect on the quality of care received. Using individual interviews, the present study explores the experiences of trans* individuals in regards to the gendered language used by medical providers; allowing trans* individuals' voices to be the primary driving force behind forthcoming recommendations.

General Interview Method

Individual interviews were chosen as the preferred space for participants to be able to disclose personal information and share their experiences. I designed the study to highlight the voices and experiences of trans* individuals. The interviews with trans* identified participants create a portrait of trans* experiences and are crucial to providing insight into the health care received by trans* individuals.

The method of interviewing varied depending upon the needs of the participants and many chose to do their interviews through email as it was the most convenient for them due to busy personal and work lives. I attempted to provide all participants with as many possible interview options for them to choose from in order to allow them the control over determining how they would participate and also to ensure that their participation was convenient and comfortable for them. Participants who asked for email interviews were sent an initial set of questions which was the same as the initial set of questions use in the in person and Skype interviews. After receiving participants' responses I sent a second set of probe questions based on their answers, usually drawing from my predetermined list of probe questions. All interviews concluded after the participants second set of responses to the probe questions. In the participants second set of responses

they usually in some way expressed that they did not have more to say on the specific questions.

As the interviews consisted of each individual's own story and in depth experiences, the interviews have high validity (Babbie, 2007). The reliability of the study is weakened by the difficulty that would be had in attempting to replicate the personal stories shared by participants. However, as one primary intention of the study is to provide agency to trans* individuals in their healthcare and voicing recommendations, the validity of the interviews outweighs the issues in regards to reliability.

Interview Structure

The participants were given the option of choosing between in person interviews, email interviews, or through Skype¹⁶. A total of twenty interviews were conducted with trans individuals. Of these interviews four were conducted in person, two were conducted via Skype, and fourteen were conducted through email. The majority of the participants choose to do their interviews through email because they were not located close enough to do interviews in person, or found it was easiest to work it into their schedule and allowed the most flexibility. None of the participants expressed a desire to do the interview through email out of discomfort or to protect anonymity. The email interviews, while not in person, maintained my intention of a continued exchange of ideas that would be allowed for in the in person interviews. During the email interviews I was able to build relationships with the participants through the email contact itself, as well as through the back and forth of the questions and expanding upon their answers.

¹⁶ A free online video chat service that can be downloaded at no charge and used to video chat over the computer with any other individual using Skype for no charge.

While the interviews included a set list of questions, the interview style allowed for the interviewees to have some control over their responses and allow them to expand into their own concerns that the pre-determined set of questions may have not covered. The interviews were expected to take approximately one hour, however the interview times varied between twenty one minutes and sixty five minutes, depending upon how much the participant wanted to share. The average interview time was forty six minutes. The interviews that were conducted either in person or via Skype were recorded and transcribed. Each participant was asked to look through their transcription to ensure that they were represented appropriately and were given the option to add anything to their interview that they may have not mentioned previously but wanted to include.

Interview Content

The in person and Skype interviews were semi-structured, conversation style. I began each interview with a pre-determined list of questions to ask during each interview along with a list of possible probe questions as needed. During each interview I would begin with asking demographic questions, followed by background questions regarding the participant's coming out processes and healthcare status, and would then move into the primary interview questions. The primary interview questions revolved around their experiences with medical providers, disclosing their gender identity to providers, provider assumptions, and the use of gendered language within these spaces. The participants were asked to provide any positive and negative experiences they have had along with the reasons why they perceived these experiences in such a way. For a full list of the questions that were asked of the trans* interviewees please see Appendix A.

Participant Recruitment

I recruited the participants using snowball sampling. I began by speaking to personal contacts I had within different trans* communities and asking individuals to share information about my study and my contact information to people they may know. I sent recruitment information about my study out on trans* focused listservs that were sent to people from across the country and posted recruitment information on a variety of social networking sites.

Trans* populations are not visible or easily accessible groups due to discrimination, transphobia, and cissexism¹⁷ that keep trans* individuals invisible within larger society. Many trans* individuals may not openly identify with everyone in their life¹⁸ to everyone in their lives or what is often referred to as stealth¹⁹, which increases the difficulty in reaching these individuals. Because of the difficulties in reaching trans* individuals, snowball sampling was the ideal method of recruitment and allowed as well for individuals to decide for themselves to contact me to participate based on their own comfort level (Babbie, 2007). While snow ball sampling does not allow for generalizations to be made about the information acquired, the intention of the study is to provide a platform for the experiences of trans* individuals to be heard and not to represent the experiences of all trans* people.

¹⁷ The belief that trans* identities are less legitimate than cisgender or cissexual identities. That cisgender and cissexual identities are the only correct, valid, or real gender and sex categories and should be treated as superior to trans* identities.

¹⁸ This is commonly referred to as “being out” or in reference to an individual being “stealth. The term “out” comes from the phrase “out of the closet” which has been used when referring to LGBTQ individuals disclosing their sexual orientation or gender identity. Stealth refers to individuals who choose not to disclose their trans* status to others. Individuals could openly identify to only family, only friends, only specific people, etc. The term stealth is considered offensive by a large amount of trans* individuals as it implies that something is hidden or that there is a deception occurring. This phrase “coming out” has also been disputed as implying that individuals should be disclosing their identity, or that disclosure is expected. To avoid using this language, in this thesis I will refer to individuals disclosing or openly identifying.

Participant Criteria

In order to participate in the study, individuals had to meet two recruitment criteria: 1) Individuals had to be at least 18 years of age or older; and 2) Individuals had to self-identify as trans*. Recruitment flyers and information provided extensive information about who was included in the researcher's definition of trans* in order to communicate that the study was inclusive as possible of all trans* identities.

Participant Demographics

A total of twenty interviews were conducted; please see Appendix B for complete participant demographic information in the Participant Chart. In terms of gender identity one participant self-identified as transmasculine, one identified as a trans guy, three identified as transgender/male, three identified as trans men, one identified as a woman, three identified as trans women, five identified as female, and three identified as genderqueer. Participants were asked the question "What is your sex?" without restricting or defining the context of the word sex. Some participants clearly separated their identity in terms of sex and their legal sex, others provided one answer. Nine participants responded by answering female, six answered male, one answered "Legal sex: male, Identity: Female," one answered "assigned female (loosely identify with it)," and one stated that they would answer male because it was what they needed to put when they applied to jobs.

The participants predominantly identified as either black or African American (four participants) or white/Caucasian (nine participants). Three participants identified as either biracial or multiracial (Biracial, White/Latino, and Filipino/Mexican). Only one of the participants identified as Indian, one identified as Korean, and one identified as Japanese.

In terms of gender and racial identity, four participants were white and identified along a masculine spectrum, four were people of color and identified along a masculine spectrum, five participants were transfeminine people of color, three were white and transfeminine, two white individuals identified as genderqueer, and only one person of color identified as genderqueer. The participants varied largely in age from 20-64, with the median age being 28 and the mean age as 34.

Ethics

To ensure the confidentiality of the participants, each participant was asked to choose their own pseudonym to be used for the study. Having participants choose their own pseudonym continues the process of providing trans* participants with agency over the way in which they are represented (Reinharz, 1992). Participants largely voiced appreciation for their ability to choose their own pseudonym.

Before beginning each interview I discussed with each participant the focus of the study and the motivation behind the study of improving trans* health care. Participants were encouraged to ask me any questions they had regarding myself or my thesis topic. I worked to establish trust with my participants through openly identifying and providing my intention of conducting research from within the community and having participants' voices as central to my thesis. I believe this helped to alleviate the participant/researcher power dynamic.

Throughout the study I have continued to be in full adherence to the IRB. For a copy of the IRB please see Appendix C. All participants were required to sign a consent form before being interviewed. For a copy of the informed consent please see Appendix D.

Data Analysis

Thematic analysis was used to examine the information collected in the individual interviews. Thematic analysis was chosen due to its flexibility and potential to present the experiences of trans* individuals as detailed as possible (Clarke & Braun, 2006). In reading the data collected, patterns in participants' responses were recorded. The data became saturated by three patterns, which became the key themes to be discussed in this thesis. Within each of these three key themes I examined the different factors that impacted each theme and compared them across the entire data set. When writing the discussion of themes, I emphasized the quotes of participants to establish not only the basis for each theme but to maintain the established goal of prioritizing the voices of trans* individuals. Names accompany participants' quotes in this thesis, except when the word or phrase was used by multiple participants.

CHAPTER FOUR:

GENDERING INTERACTIONS THROUGH LANGUAGE

The previous literature on gendered language highlights the ability of language to construct and reinforce gender within a society (Weatherall, 2002), which can be especially salient in the lives of trans* individuals. This thesis considers the experiences of trans* individuals in regards to gendered language within the realm of the healthcare services. Ultimately, this research seeks to develop recommendations for care that pose the possibility of directly impacting trans* health by improving services.

The questions participants were asked were focused on gendered language on medical forms and the language used by medical providers. During the interviews, three main themes emerged within participants' experiences of and responses surrounding gendered language: 1) the Impact of Gendered Language on Medical Forms on Provider/Participants Interactions, 2) Whole Person, Well Being, and 3) Misogyny and Privilege.

First, the language used on medical forms was discussed as something that could be highly frustrating for many, limiting, increased experiences of invisibility, and was potentially validating or affirming for other participants. Regardless of participants reaction to the language used on forms, the majority voiced a belief that changes should be made to most medical forms. Second, overwhelmingly participants made note of the importance of their doctors respecting their identity in their overall healthcare experience. Many of their responses focused on the way in which the doctor spoke to them and the effect it had on the way they experienced their care; I discuss this as Whole Person, Well Being as the participants responses often centered on the feeling of being seen as a

“whole” person, or as their “entire” self improving their experience of care. Third, throughout the interviews, participants’ responses showcased the underlying impact of misogyny and privilege on their experience of their healthcare, expectations of care, and interactions with providers. The experiences often varied in the way in which doctors’ language and interactions were contextualized and discussed by trans* individuals who were assigned male at birth and trans* individuals assigned female at birth.

In approaching this research I specifically wanted to address all types of gendered language based experiences that trans* individuals have had, including positive, negative, and affirming experiences. An important observation was that the majority of participants reported at least some positive experiences; with two participants stating they had “neutral” experiences and one stating they had had no positive experiences. The positive experiences that participants shared were most often in reference to their current or most recent primary provider. However, it was clear that their most positive experiences were not representative of their history of healthcare experiences. Many participants spent a great amount of time looking for the right providers; their positive experiences were largely experienced in contrast to a history that included numerous negative experiences with providers.

Framing the Interaction: Gendered Language on Medical Forms

The language discussed on medical forms became a dominant theme discussed by participants. This was important because it was often the first experience with the medical office and began to frame their overall experience. Participants predominantly reported seeing medical forms that largely asked one question that either said “Sex” or “Gender” and allowed only the options of “male” and “female.” Twelve of the

participants also reported seeing forms at their current or another health facility that provided an option for “transgender” in addition to the male and female options.

Participants also mentioned seeing a third option for “other.”

The almost universally binary language used on medical forms was discussed by 19 of the participants as either problematic for themselves or for other trans* individuals they knew. Participants shared that they knew going into the forms that they would be limited in their options: “I guess pretty much whatever the form asks, I know it’s always never going to be enough” (Serena). The lack of options provided on medical forms caused many of the participants to feel “invisible” and “left out.” Very common in the responses from participants, was the feeling that the options on forms were reductionist: “I don’t think my identity can really be summed up in just one option” (Brittanie). The feeling that these options reflected an attempt to “box” in participants influenced many participants to reject the options provided or “writing around” (Skye) what was provided: “I don’t check the boxes, I create my own and write it in, but I still see the paperwork afterwards and based on what I write, they check whatever box they want” (K.). Another response to the options provided was to not answer at all: “I don’t pick either, I leave it blank because it just doesn’t feel right to me...I don’t think either of those boxes really helps them to know anything about me” (K.). Boots shared how they would not mark any options if there was not one provided they felt appropriate but realized by not marking anything they still felt invisible: “I just made myself not exist” (Boots).

The individuals who experienced the most trouble with the language of medical forms were gender non-conforming individuals and individuals whose gender or sex identity did not match their legal sex. For individuals whose gender or sex identity did not match

their legal sex, the forms proved especially difficult due to insurance discrepancies. All participants showed an understanding that the question of sex or gender on almost all medical forms is for insurance purposes and not to actually give the doctor any information about who they were or how they identified: This distinction was frustrating for many participants because they felt that their identity was not seen as important to the provider or facility when the only thing they seemed concerned with on their form was insurance: “They want to know what my insurance says so they can get paid, how I feel or identify as a person is second in priority at best” (Emmit).

The options participants were provided on forms and the language used impacted their expectations of the care they would receive. When the language of medical forms included more options than male or female, Brittanie stated that she felt “respected or visible in that space...more comfortable overall.” The expanded language on medical forms allowed participants to expect their provider had some sort of knowledge of trans* identities which increased expectations of the care they received:

You can expect the center to care about your needs when you see that since they went through the effort of changing their forms... It doesn't only show that they know what a trans person is, but that they made a space for you! (Eve)

...at least you know that this exists outside of just the binary, and so if you are educated about it then I am more likely to feel comfortable going forward. So I think that even the intake forms really really make a big difference for me. (K.)

...then I just feel like--thank you for allowing me to be here! Thank you for tolerating my existence. (Boots)

One participant in particular made note of the impact they felt such language had on creating a welcoming space because it did not target trans* people exclusively, but made them visible to all of the individuals who sought services within their providers' office:

You know the fact that every new patient they ever had, had to acknowledge that process, either male, female, or transgender, I think that spoke a lot to me and it felt very empowering to me as a patient that I could receive the best care possible. It instilled a lot of confidence in me, in competent care providers (Lisa)

One of the questions participants were asked was if they had ever experienced language on medical forms that affirmed their identity. The majority of respondents said no to this question, but a few stated that had at least once been to a health center/office that used affirming language on its forms:

At the Planned Parenthood in Massachusetts... they had really inclusive forms that really separating everything instead of trying to minimize and wasn't always gender specific... it was amazing and they were actually questions that I could answer (Teddy)

Twelve of the participants specifically mentioned experiencing affirming language on forms at Planned Parenthoods (different locations in different states). The language used on forms at Planned Parenthood was described as being open ended largely, including asking questions about sexual history and behavior that were not limiting in terms of gender.

Still, for other participants, the discrepancy between the form and their identity was seen as simply an irritating hurdle to pass at the doctor's office, but did not feel it impacted them personally. A few participants expressed that they were able to separate their individual self and personal life from that of the medical or institutional setting: "I would struggle with those options in my personal life, but... I really just don't care or let it affect me. I'm not in their office very long anyway" (Brian).

Some participants voiced that while they were frustrated with the forms at specific locations and times, it didn't matter to them personally because they may not use them anyway: "I struggle with answering Male/Female/Trans more than Male/Female on the

intake forms. Easier for me to mark Male than to mark Trans” (C.). Often participants felt “scared” to mark themselves as trans* on the forms. They were concerned with the possibility of their identity not being “respected”²⁰, their identity impacting their treatment and services, being denied services, and from not believing the doctor would see them as real: “I feel like I would be denied on my identity alone” (Jesus).

Many of the participants expressed that they did not believe that their providers would see their identity as real or legitimate. Instead they felt that their identity would likely be critiqued, questioned, or even laughed at. This feeling stood out as especially significant for the 3 participants who identified as genderqueer²¹. All of the genderqueer identified participants in the study shared the belief that if they were to discuss their gender identity with their provider their provider would not understand:

I don’t expect them to get it because most people don’t and it’s outside of the way doctors, or the medical industry, sees people in a binary way. I would expect instead to receive more condescending language, a million irritating questions, offensive looks, oh and probably that would take up my entire appointment so I don’t see the benefit. (Emmit)

I would expect a barrage of questions that just aren’t medically relevant... I’m not going to bother explaining it to them because number 1. They are providing me health care. This is my HEALTH. I don’t know what they can do to me, which is a big safety issue too so maybe I’m just paranoid but I don’t want to take that risk. (Jesus)

I have to convince people that I’m gender variant. I’m a mythical creature that doesn’t exist. (Boots)

²⁰ This lack of respect was discussed as potentially being a refusal to use the correct pronoun and name, general disrespect of them as a person, or their identity not being taken seriously.

²¹ While it is impossible to create a single definition for any gender identity as each individual defines themselves differently and what their identity means to them, in order to contextualize the significance of the experiences of genderqueer individuals I will provide a broad commonly accepted definition of genderqueer as an identity category that is outside of the socially and culturally constructed binary categories of man and woman.

It is also important to note that out of the 20 participants, only the three individuals who identified as genderqueer were not out to at least one of their current or previous providers. Instead, the three genderqueer participants said that they either do not answer gendered questions on medical forms or they use their legal sex with their providers. The expectations that providers will not understand the identities of genderqueer individuals is impacted by not only the history of pathologizing trans* identities by providers, but by the lack of knowledge amongst providers of trans* identities and the binary view of gender and sex (Roughgarden, 2004; Serano, 2007).

The language on medical forms was also not much of a personal concern for individuals who had undergone some type of sex reassignment surgery and had changed their legal sex. Two participants described that their current or most recent experiences completing forms has not been something of concern for them as they now do not experience any discrepancies with insurance, the state, and their identity: “I find now it’s actually very validating to be able to just mark female and not give it a second thought after all the years of never being able to” (Mary). However, both participants still noted that the forms did cause them to struggle before their legal sex was changed or that they were aware that the forms were exclusionary to other trans* individuals in their lives which did bother them.

The intake forms were also discussed by a few participants as being an opportunity for the staff and providers to make assumptions about their identity. Two transmasculine participants shared experiences where a provider assumed they were trans women based on their forms and appearance:

If I mark Trans as my gender on a form but it does not ask (FTM or MTF) because I pass extremely well as male they tend to assume I'm a transgender woman. (C.)

I went to a new gynecologist and on my first visit I mentioned penetrative sex and she was like "you mean anally?" and I kept saying no, but she seemed really confused and I ended up just being like "I was born with a vagina." She had assumed I was a trans woman coming to her wanting surgery... I didn't go back there. (Teddy)

Universally the participants expressed the need for medical forms to expand in some way. While one participant suggested adding "transgender" as an option, nineteen participants suggested some type of open ended response. Many suggested as well that there should be a space for individuals to provide the name they would like to be referred to by and their pronouns. A few participants also mentioned that questions that ask for sexual orientation are often difficult to answer because of the sex or gender of their romantic or sexual partners not necessarily aligning with the assumptions of providers:

My primary care physician, when she was inputting everything into the computer under sexual identity she clicked bisexual and I said, "I am not bisexual, I don't identify as bisexual. I have a problem with you checking that box off for me and non-consensually labeling me as bisexual, I identify as queer." (K.)

Participants suggested expanding sexual behavior and identity questions to not rely on gendered language by asking the question "Who do you have sex with?" or "Who are you attracted to?" and allow individuals to fill in a blank space.

Discussion. What participants found to be limiting in the questions asked on forms was consistent with the bio-medicalized view of sex/gender as naturalized male or female (Morgan, 1998). Participants struggle with answering these questions reflects the fact that these categories are not unproblematically binary. Joan Roughgarden (2004) argues that while the biological community has begun to acknowledge the social construction of binary sex categories, the medical community has held strong on maintaining these

categories. Anne Fausto-Sterling (2000) is another biologist who has continued to challenge the notion of two sexes. Like Roughgarden (2004), Fausto-Sterling (2000) argues that the medical community enforces a binary sex and gender system on individuals from the time of birth when sex is coercively assigned. When participant Emmitt references feeling as if providers do not care about their identity, it reflects the biomedical paradigm that has worked to erase and make “invisible” those individuals and identities that do not adhere to the binary medical model.

Similarly, participants who felt that the forms were not as much a problem for them personally because they could separate the doctor’s office from their personal life reflect the separation between the medical world and the world in which participants were themselves (Morgan, 1998). These participants were willing to compartmentalize themselves in the manner that the medical paradigm desires for them to do. As will be discussed more in the next section on well being, participants were expected to acknowledge only specific parts of themselves at a time instead of viewing themselves as whole.

The medical paradigm experienced by participants not only provided prescribed sex/gender options but often showed trans* participants that their providers did not have their best interests in mind. Many voiced frustration with knowing the forms only wanted information for insurance purposes and were not concerned with how individuals identified. This understandable encouraged participants to feel, at the beginning of the appointment, that they had to be guarded from their provider.

Whole Person, Well Being

As discussed, many of the participants described themselves as “struggling” with the limiting options provided on the medical forms. Often participants mentioned the specific feeling of being put into a box. Many of the participants did not feel like their identity could be explained or summed up within one box, option, label, or answer: “I feel like a lot of my life experience isn’t represented when I choose one or the other” (Eve). This limitation in choosing how they are represented in forms often carried over to their experiences with providers. The “struggle” and “frustration” for many participants came from wanting all of their identity, and their whole selves, to be seen by their provider:

I’m not the same as just ‘gender: woman.’ Like there are a lot of different things going on that you really need to know about so that you can treat my whole self and that I can receive the best care possible. (K.)

Throughout the interviews, participants clearly expressed the desire for their medical provider(s) to see them as they see themselves. For some participants this meant that it was crucial that they had more options on forms or were able to discuss their identity with their provider in order for them to see all aspects of who they were (at least in terms of gender):

It’s important for the doctor to know not just the body of the person but their identity, I mean, they are a whole person right? Like if you aren’t doing well emotionally you probably aren’t doing well physically. (Brittanie)

I feel like my identity is really complex, and the way I interact with my gender is so fluid, yet I am really sensitive to it. Not having my doctors know really impacts how comfortable I am because I’m constantly guarded. (Emmit)

A number of participants voiced that their gender history shaped who they are as a whole, and is important in their sense of self:

Just like there is importance in being able to be open about who you are in that setting it’s important to me that they actually see me for me and that involves all

of me. Not just my current state, and even my current state is influenced by where I've been. (Eve)

When participants feel like their gender identity is recognized, respected, and understood by their providers they are more able to let their “guard down”:

I think because my doctor sees me as a whole person that makes a huge difference... I never have to worry about gender being an issue so it allows me to focus on my health and taking care of myself. (Skye)

For trans* individuals there are an endless amount of interactions and situations in everyday life that force awareness of their gender; this constant awareness and often feeling the need to prove one's gender can lead to a great deal of emotional stress and anxiety. By feeling like their provider truly sees them as their correct gender, the trans* identified participants in this study felt they are able to focus solely on their health:

I feel like it's like having to hide being gay at work while everyone else gets to talk about their wives and kids and you have to avoid the topic, it's not a good environment, and I feel like going to the doctor and having to hide my gender identity and be treated in a way that doesn't align with my identity doesn't help me get better. It's like a toxic environment that's high stress, where as being respected for who I am allows me to let my guard down and just get the care I deserve. (Eve)

While the correct use of pronouns and name were mentioned as important by the majority of participants, the gendered language experiences that participants shared as having been particularly meaningful or influential to them often involved the ways that they are spoken to by their providers overall. Participants were significantly aware of the subtleties of gendered language in their interactions with providers; often picking up on things such as the provider's tone of voice or use of terms of endearment. Transfeminine participants consistently mentioned hearing terms like “dear,” “hun,” “darling,” or “sweetheart” which helped them feel affirmed by their providers. When providers speak to participants in a manner that aligns with their gender identity throughout the whole of

their interactions, they are encouraged to feel that the provider is truly viewing and treating them appropriately which they felt impacted not only their experience but improved their health. One example of this was shared by Kate, who said that she once went to an urgent care center due to kidney failure and was in very dire health when a doctor with whom she did not discuss her identity was able to tell how she identified and on their own began speaking to her “gently” and “the way you would speak to a young girl” (Kate). The comfort she experienced by having her provider take the time to affirm her gender she feels directly impacted her ability to get better. K. also shared his experience going to a “regular” Canadian hospital for a surgery and found all of the staff and providers understood and respected his identity. During the time he spent in the hospital K. said he never had to explain himself, and yet everyone spoke to him correctly which allowed him to focus on his recovery without worrying about his safety or having to explain himself.

Participants also discussed their comfort when providers discussed their bodies. When providers made at least an effort to be sensitive to the possible effect of using gendered language to refer to participants’ bodies, they were more likely to feel like their doctor cared about their feelings and identity, not just their physical health:

I had a gynecologist once try to refer to my clit as my penis, which while I know a lot of guys like that, it just feels strange to me. I told her it was fine that she didn’t need to do that, but I felt massively more comfortable around her after she tried.
(Franklin)

The terms male-bodied and female-bodied were brought up as problematic for a number of participants. Participants not only were uncomfortable with their providers’ assumptions, but with their provider labeling their body as something they did not agree with:

I have a problem with female-bodied and male bodied. I am male, this is my body, therefore I'm male-bodied. (K.)

...the phrase male-bodied and I've often heard that and it's extremely uncomfortable. I don't see my body as a male body nor should it ever have been a male body. (Mary)

It's so offensive to me. Listen if I'm coming in here and telling you I identify as a woman and you're going to them separate that identity for me from my body and call me something else? Fuck you my body is part of my identity, don't try to separate me up, it's a package deal, a FEMALE package deal. (Elle)

Throughout the interviews an interesting theme occurred when participants discussed their experiences that were viewed as positive or affirming. As has been mentioned, a few of the participants mentioned having seen language used on forms at different Planned Parenthoods that affirmed their identities. Participants also continued to mention Planned Parenthood specifically when discussing their experiences that were positive or affirming. Out of the twenty participants, twelve mentioned at some point in their interview that they had a good experience at a Planned Parenthood in relation to the use of gendered language. Planned Parenthood was brought up by individuals across identities and from various parts of the country.

Participants who discussed Planned Parenthood in terms of their interactions with providers overwhelmingly saw the way that they were treated as appropriately gendered throughout all aspects of their care, and often referred to these experiences as more than just positive. Participants' experiences with Planned Parenthood often portray staff and providers going beyond using appropriate language and emphasizing gendered interactions that resulted in the participants feeling that their providers were invested in caring for who they are as a person as well as their health. Kate shared how during one of her first visits to a Planned Parenthood where during the physical examination her

provider stopped and asked her if she would like to have the exam done in the stir ups. While the stirrups are often dreaded by individuals who have been asked to scoot down and relax, the provider's offer, which Kate was eager to accept, gave her an appropriately gendered experience far beyond using the correct pronouns. This story showcases the provider's sincere efforts to affirm Kate's gender in all aspects of care. One participant described an experience at Planned Parenthood where they felt their gender had been affirmed in a manner that most aligned with their own sense of self as opposed to the gendered language they most often experienced elsewhere. During a visit to a Planned Parenthood to receive a Gardasil shot, Teddy shared that the nurses and staff who were around him as he waited went out of their way to speak to him in an affirming manner; continually coming over to him and telling him how great of a guy he was for getting the shot and that more guys should be considerate like him and get it. He describes this experience as one where the nurses interacted with him in a manner that was much more aligned with his gender identity as they affirmed their view of his masculine gender identity without resorting to using the hegemonic masculine discourse that he had previously experienced.

Participants' positive and affirming experiences with Planned Parenthood all contain the underlying concept of providing for the whole of a person. What makes these experiences positive, including mentions of the gendered language on medical forms, is the emphasis on seeing and respecting a person in their entirety and providing care in a way that is conscious of continually affirming the gender of the individual throughout all interactions.

Discussion. The framing of Whole Person, Well Being in this thesis was based on the continued use of the words/phrases “whole,” “entire,” or “all” by participants when describing how they want to be seen by their providers. Having their providers see the “whole” of who they are, was consistently attributed to feeling more comfortable and improving their experience with providers. The basis for such feelings by participants was imbedded in the way in which their providers spoke to them and affirmed their gender identity.

Participants felt that their providers’ were not viewing all of who they were or their identity when they used phrases like “male-bodied.” Dean Spade (2011) argues that the use of gendered or sexed words to refer to bodies works to separate identity from the body and compartmentalize individuals’ identities. Emily Martin (1987) has argued as well that the medical community has long strived on disemboding individuals identities.

The positive and affirming experiences that participants had at Planned Parenthood speaks to the different motivations and ideology held by those workers as opposed to the general medical ideology of most medical providers. Workers at Planned Parenthood are likely to be drawn to the organization due to some level of desire to do what is often considered feminist work (Joffe, 1986). The type of individuals that choose to work at Planned Parenthood are more inclined to hold a gender consciousness that is different from the “diversity” focused trainings that many LGBT health centers receive and perform. The providers at Planned Parenthood were often described as being able to understand how to affirm their patients’ gender, without having worked with trans* patients before. This ability to provide quality, affirming care for trans* patients without any trans* specific knowledge or training showcases the ability of Planned Parenthood

providers to understand the needs of trans* patients by just understanding gender. Not only do these providers understand gender, but were repeatedly described as affirming participants gender in a way that cared for all of their whole selves.

As opposed to the medical paradigm that encouraged participants to disembodiment their identity, a feminist health paradigm has predominantly focused around the need to view the individual as whole (Morgan, 1998). Many women's health movements over the past hundred years have pushed for the need for whole person care. While the origin of Planned Parenthood is not located in a feminist health paradigm (Joffe, 1986), it is clear that the workers at these locations bring in feminist health practices of whole person care along with gender consciousness in their care of trans* patients.

Misogyny and Privilege

Throughout the twenty interviews, participants described the influence of misogyny and privilege on not only the experiences with providers but in the way in which experiences were contextualized. While many scholars and activists have addressed and defined what is referred to as transmisogyny, a term coined by Julia Serano (2007) to refer to the forms of misogyny used against trans women, in this thesis I will be using just the term misogyny to include all forms of misogyny, including transmisogyny. By using just the term misogyny I intend to emphasize that all forms of misogyny experienced and enacted share the same root. Experiences of misogyny and privilege impacted participants differently based on whether assigned female or male at birth.

Privilege. One of the most evident themes noticed in the participants' stories was the impact that misogyny had on individuals who were assigned female at birth and their interactions with medical providers. This is particularly insightful as common discourse

around transmasculine identities often argues that transmasculine individuals are presumed to receive male privilege. Participants who were assigned female at birth continually expressed not only a distrust of medical providers, but shared experiences of being spoken down to, spoken over, belittled, or being treated like a child by their providers when their sex assigned at birth was known:

Until recently, like a few months ago, when I got a new primary care doctor who is a woman, I felt like I never had a say in my care. I was always told what to do, never asked. I was a kid to them who was too stupid to make decisions. (Franklin)

Of the participants assigned female at birth, many clearly voiced that they experienced a difference in the way that providers treated them when they were read as men compared to how they were treated once they shared their trans* identity. The change in treatment based upon their provider's perception of their gender and history often moved from feeling like they were allowed more control and their voice was respected more when they were read as men, to feeling as if they were not in charge of their health care and had no ability to advocate for themselves when their providers knew of their sex assigned at birth:

I think it speaks to male privilege and how the moment they know I'm trans that goes away. I get treated just as I did as a woman, I get talked down to and disrespected... being silenced in my concerns and forced to respect their authority. (Jordan)

The doctors seem to take a more dominant stance in those cases [when they know I'm trans] and tell me what is going to happen/what I need, etc. instead of consulting with me as if we were on the same level which they have done when they read me as male. (Asher)

The privilege participants who were assigned female at birth experienced in situations where they were read as men was also something that participants were explicitly aware of and uncomfortable with:

The first time I went to a doctor and didn't come out as transgender I remember it being really surreal. The guy ended up speaking to me and my wife completely, blatantly differently and I realized how this jerk thought I was somehow more intelligent than her because he thought he knew what was in my pants. I don't want that. Having experienced that bullshit my whole life the mere fact that he was trying to give me privilege over her made me never come back. (Mark)

Mark's clear discomfort with the privilege afforded him in this situation can be attributed to what Patricia Hill Collins (1990) refers to as the outsider within perspective.

Regardless of Mark's gender identity, having experienced the world at one point being socialized as female provided him an awareness of the gender inequality in his treatment, causing him to feel uncomfortable.

Participants' experiences of privilege were contextualized in the way their provider viewed them and their previous history. Specifically in terms to the experiences of trans* participants assigned female at birth, being granted male privilege was described as temporal and conditioned on their providers knowledge of their sex assigned at birth. Participants' experiences of privileges they were afforded was viewed through their personal histories. This lead to an increased awareness of their privilege and often lead to feeling uncomfortable with the treatment they received.

Participants' relationship between terms of endearment and gender are reflective of the predominant feminist literature on gendered language. Terms of endearment are often a way in which to enforce gender through language, and have been largely framed as having negative attributes (Weatherall, 2002). While feminist scholarship has labeled such language as patronizing or condescending, trans* participants assigned male at birth found this language to be affirming (Weatherall, 2002). This difference in perception may be attributed to individual's experiences with the use of these words. Participants assigned male at birth may have not experienced the negative connotation with words

like “sweetheart.” The difference in gendered language history for trans* participants assigned male at birth and participants assigned female at birth likely impacted the way in which these words were experienced.

Body language. Misogyny was also evident in the way in which participants who were assigned male at birth were spoken to by providers. The participants who were assigned male at birth significantly voiced having at least one provider at some point in their history of care make a comment about their body and suggesting (and primarily assume) that they have feminizing surgery. The provider emphasis on surgery was not something discussed by participants assigned female at birth. A few of the participants who were assigned male at birth shared that they had not experienced much unhappiness regarding their own body until having a provider suggest that they have surgery, such as breast augmentation, to appear more feminine. One example of this was shared by Serena whose provider suggested she look into having bottom surgery: “That day though I definitely experienced a great deal of self-loathing” (Serena). Another participant, Mary, stated that comments made by her provider impacted her decision to have electrolysis done to remove hair. Their experience of body policing is deeply imbedded in misogynistic attitudes toward the appropriate appearance of femininity. As well, trans* participants who were assigned male at birth shared significantly more stories reflecting the male/medical gaze to whom their bodies were expected to be appealing, regardless of how they felt about their own bodies.

Trans* participants who were assigned female at birth also shared their experiences with providers commenting on their body when they were aware of their identity. Jordan told how during a gynecological visit, his provider made references to how large certain

parts of his genitals had gotten and referenced how they could be used. Jesus also discussed their experiences with providers commenting on the gendered aspects of their body: “I remember my breasts were always the center of attention and I never liked them so it was really awkward” (Jesus). Rather than the policing of femininity experienced by transfeminine participants, participants assigned female at birth shared stories that reflected the misogynistic entitlement to their bodies and the right to comment on them.

The gendered language experienced by trans* participants assigned female at birth and participants assigned male at birth, while both emerging from misogynistic beliefs, were enacted differently in referencing participants’ bodies. Participants assigned male at birth experienced high amounts of body policing. Their way their bodies looked and what should be done to make them adhere to feminized body norms policed and disciplined participants’ bodies. The effects of providers’ attitudes toward their bodies encouraged many participants assigned male at birth to pursue medical or surgical changes. Participants assigned female at birth experienced language around their bodies that did not necessarily police or regulate their appearance, but instead highlighted the medical/patriarchal entitlement over the bodies of individuals assigned female at birth. The comments they received were not directed at what participants should do with their bodies or how they were expected to look. Instead their bodies were a place of open access for commentary by providers, particularly the sexualized aspects of their bodies.

Intersections of misogyny/privilege and race. Participants of color the lack of expectations from medical providers was most evident with participants explicitly stating that their history with medical providers taught them not to expect anything:

As a black man with a woman’s history I don’t think the medical community has much respect for me and I’ve seen it over and over again. (Jordan)

I can say that I should have received better care, but I know I'm going to have to fight to get it. I know nothing is going to be handed to me and I've been disrespected by doctors enough to know that. (Elle)

Participants of color also experienced discrimination and offensive language from their providers that was compounded by their race or ethnicity. Brittanie shared how a doctor told her once that she was “lucky” she was a person of color because she would be able to “pass better.” Brittanie also mentioned having a nurse make an offensive comment about her appearance saying “girls like you,” in which she first thought was referencing her trans* identity but when she responded to the nurse found it was in reference to her ethnicity. It was clear in the interviews that participants’ race and ethnicity played a large role in the amount of privilege they were allotted by providers, and the way in which providers spoke to them.

Gender, misogyny, and expectations of care. Participants who were assigned male at birth often experienced a distrust of their providers, and had shared more experiences of blatant verbal discrimination/harassment and refusal of services than participants who were assigned female at birth. Despite the negative experiences, difficulties in finding new providers, and what a few expressed as a fear of further discrimination by providers, participants who were assigned male at birth were far more likely to believe that they could still find someone that would provide them quality, competent health care and were willing to look until they found them. This optimism regarding their healthcare coincided with another trend in participants’ responses involving an expectation of the care that they should be receiving. Out of the twenty interviews, participants in only six interviews used the term “deserve” or “deserved;” what is worth nothing is that these six interviews were all with participants who had been assigned male at birth. Neither term came up at

any point in the 11 interviews of trans* individuals assigned female at birth nor in the other three interviews of participants assigned male at birth. Each time the term “deserve,” or a variation of, was used by participants was in context of saying that they knew or felt they deserved better care, even when they had experienced blatant discrimination:

...at the end of the day I knew I deserved better care and I deserved to be happy. I couldn't let them stop me from being healthy or they would win. (Mary)

Patients are the ones receiving the care and paying their bills, we deserve respect and to feel comfortable. (Brittanie)

I think it's reasonable to think I deserve good healthcare, everyone does... (Serena)

While I would argue that all individuals do deserve to receive competent, quality, accessible health care, participants' statements that they deserved cared were in stark contrast to the majority of the interviews with individuals assigned female at birth who voiced largely that they didn't expect providers to treat them well or fully care for them: I just expect the bare minimum of treatment. I wouldn't even call it care because I'm pretty sure doctors don't “care” about me, my identity, my body, my life, just their paychecks. (Jordan).

One participant, Asher, was more vocal about the role that misogyny played in his expectations of care: “I only see female doctors... I'm not comfortable with the idea of seeing a male doctor, especially since I don't really believe a cis male doctor would respect my identity.” When asked to explain further why he felt this way, Asher responded:

A male doctor goes into everything with male privilege. He might view me as having that too, now that I am consistently read as male, but once he finds out I'm

trans, that's stops... The [cis] guys definitely don't include me as "one of them" anymore when this happens... I am more comfortable around people assigned female at birth, especially if they are going to have some power/authority over me, such as a doctor... And since he would be coming from a place of dominance/privilege, it would be more like I was having to prove/justify my identity to him. I wouldn't expect him to respect me. (Asher)

Asher's expectation that a cisgender male provider would not respect his identity exemplifies the perception of providers shared by the majority of the participants assigned female at birth.

Discussion. The participants who were assigned male at birth that expressed they deserved better care are likely to have been influenced by previous experiences, pre-identifying at least openly as trans*, in which they felt like they received good care and from that held the reasonable assertion that they should still be able to receive the same level of care. Considering the inadequate, and often hurtful, care that has been found to be received by individuals assigned female at birth (Laurence & Weinhouse, 1994) it is also understandable that participants who had been assigned female at birth would likely not have received health care in which they had a positive experience and do not expect to receive it.

Individuals assigned female at birth have been historically underserved and cared for by the medical industrial complex. Laurence and Weinhouse (1994) discuss how it is far too common for individuals assigned female at birth to feel that they are being spoken down to by their doctors and treated like children. This reflects the experiences shared by participants in this study assigned female at birth, who at the same time voiced low expectations of care from their providers.

The language that participants experienced in regards to their bodies highlights the importance of conceptualizing misogyny not in terms of merely the experiences of

“women,” “females,” “femininity,” or in the case of transmisogyny: trans women. What was found in participants’ experiences was the role that the patriarchal medical industrial complex took in enforcing all of these categories as interconnected. The entitlement to transmasculine individuals’ bodies discussed by participants highlights the patriarchal entitlement on those bodies assigned female at birth. This entitlement was shown to be something that even transmasculine individuals do not escape through transition, but will continue to experience. Transfeminine participants experienced their femininity policed in terms of their bodies as they were instructed how they should look. This policing in turn works to not only hurt transfeminine individuals and impose harmful self-image, but continues to police cisgender women’s bodies through the expectation of what a woman’s body should be. Susan Stryker (2008) makes the connection that the increase in policing trans women’s femininity by the medical and psychological community and the strict harmful guidelines that have been imposed, have been constructed parallel to the mainstream women’s rights movement. As it became less socially acceptable to publically police the femininity and bodies of cisgender women, femininity was able to be policed through trans women’s bodies (Stryker, 2008). All of the participant’s experiences underscore the need to view misogyny as intersectional.

Highlighting the role that misogyny and privilege play into shaping the experiences of participants with their providers allows us to recognize the context and societal factors that not only influence the language used by providers when interacting with trans* patients, but also the standpoint through which these experiences may be understood by individuals seeking care.

CHAPTER FIVE:

CONCLUSION AND RECOMMENDATIONS

Recommendations for Healthcare Providers

Having positive and respectful experiences with medical providers can improve the lives of trans* identified individuals by decreasing the stress of finding medical care, through affirmation of identities. Similarly, by having increased access to medical care trans* individuals can lead potentially healthier lives (Davis, 2009). Changes need to be made by healthcare providers and their offices to make them more inclusive, affirming, and respectful of trans* identities. Together these interviews will provide a story of trans* experience that can be used to create and change the medical care conditions for trans* individuals. Based on the experiences shared by participants, and often their own direct recommendations, I provide the following recommendations aimed at fostering more positive healthcare experiences for trans* individuals.

Direct communication. Providers should ask patients directly what language/words they are comfortable or not comfortable being used. All 20 trans* individuals interviewed said that they wished their healthcare provider would ask them this question, with none of them voicing that they would take any offense to such a question or be uncomfortable answering. Even individuals who stated that they had no problem with what their current provider said to them, still said they would like to be asked. Some trans* individuals voiced that they were at times uncomfortable coming into the doctor's office to begin with and were uncomfortable with the power or authority the provider had over them. By asking trans* individuals what language they are comfortable with, trans* individuals

interviewed said they would feel like the provider was making an effort to respect them, understand them, and make them comfortable.

Asking what trans* individuals are comfortable with also allows the provider and the individual seeking care to avoid any awkward conversation while trying to figure out the right words to say or the right way to discuss something. One trans* individual in particular stated that their provider tried very hard to respect them with how they spoke to them, yet seemed incredibly uncomfortable at times while they searched for words which made the patient uncomfortable and feeling like an inconvenience.

Expanding forms. Medical forms for providers and health centers should expand their questions for sex and gender and allow individuals to fill in their own answers. While the providers do understandably need to know what sex an individual is classified under for their insurance, they can specify a question for “Insurance Sex.” Forms should also include a space for individuals to provide their gender identity, the name they go by, and their pronouns. The answers can then be provided to staff members/medical providers before the individual seeking services is called back or interacts with the provider, allowing individuals to be referred to appropriately from the beginning of their visit.

Placing these questions on the forms works to also create a more comfortable space for trans* individuals to receive services. Many participants stated that when they see forms with such options they feel that they are being made visible by those that work in the office/center and are far more likely to feel respected and safe in these spaces.

Having questions on forms for gender identity, pronouns, and name also keep the individual seeking service from having to take time away from their appointment to

discuss all of the things that they had been able to answer on the form. Removing the conversation of having to explain one's identity to their provider out of the appointment, allows trans* individuals more attention on their healthcare needs.

Right care v. right speech. Overwhelmingly providers need to increase their gender consciousness. Trans* individuals interviewed largely described their positive experiences as those where they felt respected. Trans* individuals felt that respect was given when a provider spoke to them in an appropriate manner, and used the correct pronouns/name. However, trans* participants described experiences they found affirming as those in which the provider(s) had a much deeper knowledge of gender than just what to say. While language was evident as an important factor in all of these experiences, the difference came into how much the patient had been treated as a whole person.

In this sense, providers must move past trainings and education focused solely on “how to speak to trans* people” and move into education and knowledge of the experiences of gender and the ways in which gender impacts every aspect of patient lives. To create truly empowering healthcare experiences for trans* individuals, providers must understand how it is not about “saying the right thing” but infusing a consciousness into all aspects of the way in which providers interact with patients. This is no small order, however. Providers truly interested in providing the best care possible for trans* individuals in a space that is respectful, safe, comfortable, and affirming, will need to expand the way in which they understand gender and gendered interactions.

Changing the mindset of healthcare/gender. In order for any of these recommendations to truly be effective at improving the healthcare of trans* individuals, larger changes need to be made in the way that we address gender and trans* concerns.

Primarily, trans* healthcare cannot be seen as a specialty. The lack of education of trans* identities and the invisibility of trans* individuals from medical curriculum exacerbates the healthcare struggles trans* individuals experience. Because there are few providers with the appropriate knowledge base, trans* individuals are forced to limit their options when choosing providers and often have no providers located near them where they can receive services.

Not only should transition specific education be included in medical curriculum, but information about trans* identities and gender need to be included as well. Providers need background knowledge on trans* identities beyond appropriate terminology. Unless a larger understanding of gender as non-binary and constructed is established, providers will be limited in their ability to provide quality, competent care for trans* individuals.

The limited conceptualization of gender by providers is reinforced by society at large. Ultimately, as a society we need to reconceptualize gender more broadly in order to improve the healthcare experienced by trans* individuals. The medical community specifically, and society needs to reconsider the ways that trans* identities are pathologized and limited into categories that maintain the binary sex/gender system. While many trans* individuals have identities that can be seen as binary, many trans* identities cannot be fit into binary gender categories. For trans* individuals with non-binary identities are forced to either hide who they are or pick a label that does not fit them within the medicalized model of gender. Until trans* identities are not seen as something needing to be fixed or explained, any improvements to trans* healthcare will still be subjected to low expectations by trans* individuals.

Conclusion

The medical community over time has contributed to maintaining a gender binary system that pathologizes individuals who do not conform to the binary. This uniquely impacts trans* individuals. For many trans* individuals, doctors' offices become a place of anxiety, and at times, a place in which their gender identity is not respected. Trans* participants' distrust of medical providers expressed in this study showcases the impact that such pathologizing has had on their experiences and expectations of care from medical providers.

To improve the healthcare available for trans* individuals, changes must be made that create a more respectful, welcoming environment and experience for trans* patients. This study provided an opportunity for trans* individuals to share their experiences of gendered language with medical providers in order to provide a look into their lived experiences. The voices of trans* participants allows for the creation of recommendations of changes in gendered language use by medical providers that could directly impact the healthcare received by trans* individuals. This study has valued first and foremost the importance of trans* individuals' voices and experiences in determining what changes are necessary.

The majority of the participants reported feeling overall comfortable or willing to discuss their gender with their providers. This reflects a limitation of the study as participants self-selected to complete an interview regarding their gender identity and experiences; therefore participants were more likely to be willing to discuss their gender identity in general. The experiences shared by participants may have been different if participants had been recruited through a different method. The study could have also

presented a different perspective through interviewing healthcare providers. Conducting dual interviews may have highlighted different themes amongst participants' responses, as well as allowed for comparison of perceptions between patient/provider interactions. This may have also led to additions or more specific details in the recommendations created for medical providers.

Despite limitations, this research has showcased experiences of trans* individuals with their providers and displayed potential areas for changes to be made. Through the course of this study, I found that gendered language is not always the most important aspect of trans* individual's experience with medical providers but it does work to potentially alienate or affirm trans* individuals as whole individuals seeking care. Trans* individuals expressed the importance of their provider(s) to see them for who they are entirely and the positive impact it has on their experience, comfort level, trust, and expectations of their providers.

The impact of misogyny was also evident in the experiences provided by trans* participants. Participants who were assigned female at birth and were open with their identity to their provider(s) discussed experiencing continued misogynistic attitudes and treatment from providers as opposed to individuals assigned female at birth who were not open about their identity with their providers and were read as male, who expressed receiving suddenly better healthcare treatment and privilege. Participants assigned male at birth experienced their bodies being policed through the language used by providers that attempted to regulate their appropriate appearance. Misogynistic attitudes and the impact of privilege on the care they received was evident as well in the experiences of

participants of color who described increased experiences of discrimination which effected their expectations of care.

The term misogyny was intentionally chosen over the term transmisogyny as the experiences of participants exposed the impact that misogyny played in shaping participants experiences with providers regardless of their gender identity. The term transmisogyny was found to be inadequate to capture the experiences of participants as it examines misogyny exclusively in context of the experiences of transfeminine individuals. Traditional feminist theory and discourse of misogyny also fails to capture and include the experiences of trans* individuals. Misogyny is rarely examined in feminist discourse as it applies to the lives of individuals assigned male at birth, highlighting instead the experiences of “women” (Serano, 2007). However, queer theory and discourse has recently focused around exposing misogyny experienced by trans women—transmisogyny (Serano, 2007). Both of these perspectives alone are not sufficient in contextualizing and deconstructing the discourse that shapes and maintains misogyny within society. What is missing from both of these interpretations is the lived experiences of transmasculine individuals and trans* individuals assigned female at birth. While this study has focused on improving the healthcare experiences of trans* individuals, I also offer a recommendation for feminist scholars and activists: The discourse focused on combating misogyny must not be limited to gender or sex analysis. As the experiences of participants exposes, misogyny is enacted in intersecting ways across identities. Approaching and understanding misogyny as a complex system expanding across genders, identities, sexualities, and sex assigned at birth, opens the door for a deeper and more aggressive assault on a system of misogyny.

APPENDICES

APPENDIX A:**Interview Questions for Trans* Identified Individuals****Demographic Questions**

1. Age
2. Race/ Ethnicity
3. Gender Identity
4. Sex
5. Healthcare Status
 - a) Do you have health insurance?
 - b) If no, where do you receive medical care?

Background

1. At what age did you begin identifying as _____ to yourself?
2. At what age did you begin identifying as _____ to your friends and/or family?
3. Do you openly identify as _____ with your medical service providers?
 - a) If yes, at what age did you begin identifying as _____ with your medical service providers?

Open Ended Questions (If participants openly identify as trans* with their medical service providers.)

1. Can you tell me about your initial experience(s) coming out as trans* with your doctors and other medical providers?

Prompt Questions:

- a) Do you openly identify with some providers and not others? If so, why?
- b) What prompted this disclosure?
- c) What reactions did you receive?
- d) Was this experience challenging for you, if so in what ways?

- e) Have the reactions you received differed between any specific services (such as gynecologists, primary care, or other specialists)?
 - f) Do you think your treatment has changed since you have openly identified?
 - g) What about these experiences made them positive or negative?
 - h) If you could change anything about these experiences what would you change?
 - i) Has this ever affected you seeking medical attention or services?
2. Would anything make you feel more comfortable discussing your gender identity with your medical providers?

Open Ended Questions (If participants **do not** openly identify as trans* with their medical service providers.)

1. Can you tell me why you do not wish to or have not openly identified with your medical service providers?

Prompt Questions:

- a) What reactions do you think you would receive?
- b) Do you plan on openly identifying?
- c) Do you think your treatment would change if you openly identified?
- d) What would make you decide to openly identify or feel more comfortable doing so?
- e) Would you feel more comfortable identifying with some doctors as opposed to others? If so, why?
- f) Has this ever affected you seeking medical attention or services?

Open Ended Questions About Language (All participants)

1. Can you tell me about the language you have experienced on medical forms in terms of questions based on sex and gender?

Prompt Questions:

- a) What words/ phrases have you found most common?
 - b) How do these words/ phrases make you feel?
 - c) Do you struggle with answering questions on sex and gender? If so, can you tell me about that struggle?
 - d) Does this struggle ever affect your decision to seek medical attention?
 - e) Do you feel these words/phrases adequately represent your identity?
 - Have you ever spoken to a medical service provider about these forms and questions?
 - f) Have you ever found medical forms that used language that empowered or validated your identity?
 - If so, can you please tell me about the language used and why it was positive?
 - g) How would you prefer these questions to be asked on forms? What language or style of question would you be most satisfied with?
 - Why do you feel this would be a better option?
2. Can you tell me about your experiences with gendered language by medical service providers? With gendered language referring to any words or phrases that carry with them a direct (ex. man, woman, male bodied, or female bodied), or indirect relationship to a gender (ex. breasts).

Prompt Questions:

- a) Would you characterize these experiences as positive or negative?
- b) What language/words have you specifically experienced problems with?
- c) What language/ words have you found to be validating or affirming of your identity?

- d) Have you ever discussed with your doctors your feelings toward gendered language?
 - If so, what was that experience like?
- e) Have the words/phrases/ language used by a medical service provider ever effected the way you viewed yourself and/or your body? If so, how?
- f) Do you wish medical service providers would use other language than what you have experienced? If so, what changes would you want to hear?
- g) Has the language/phrases/words used by medical service providers ever encouraged or discouraged you from seeking medical attention or services? If so, how?
- h) Has a doctor or medical service provider ever asked you specifically what language/words you prefer? If so, how did they make you feel?

Open Ended Questions About Identity and Experiences (All participants)

1. Have you ever experienced a medical service provider make assumptions about your identity based on what you answered on the medical forms?

Prompt Questions:

- a) Were their assumptions correct?
- b) If their assumptions were incorrect, did you correct them or discuss the assumption with them?
- c) If their assumptions were correct how did that make you feel?
- d) How have you responded to providers' gender based assumptions?
- e) What do you think could be done to change the assumptions made by providers?
- f) Have any assumptions affected the way you feel about yourself and/or your body?

- g) Have any assumptions affected your decision to seek medical attention or services?
- 2. What experiences, if any, have you had in regards to your gender identity or sex, with medical service providers that have been positive?
 - a) Why do you consider these experiences positive?
- 3. What experiences, if any, have you had in regards to your gender identity or sex, with medical service providers that have been negative?
 - a) Why do you consider these experiences negative?

APPENDIX B:**PARTICIPANT DEMOGRAPHICS TABLE****Participants Assigned Female at Birth**

Name	Age	Race/ Ethnicity	Gender Identity	Sex †	Health Insurance Status	State
Emmit	20	Asian/ Korean	Genderqueer	Assigned female (loosely identify with it)	Insured	NJ
Jesus	21	Caucasian	Genderqueer	Female	Insured	MD
Asher	22	Caucasian	Trans guy	Female	Insured	MD
Brian	24	Biracial	Transgender/ Male	Female	Insured	MD
Boots	27	White	Genderqueer	Female	Insured	MA
K.	28	Black	Trans guy, Trans man	Male	Insured	MD
Teddy	28	White/ Caucasian	Trans	Female	Insured	MD
Franklin	30	White	Trans man	Female- legal	Insured	MD
C.	36	White and Latino	Transgender (F-M) Identify as male	Male	Insured	MN
Jordan	42	Black	Male	Male	Insured	CA
Mark	55	White	Trans man	Male	Uninsured	TX

Participants Assigned Male at Birth

Name	Age	Race/Ethnicity	Gender Identity	Sex †	Health Insurance Status	State
Kate	24	Caucasian	Female	I have to put Male when I apply for jobs	Insured	NC
Eve	22	Black	Woman	Legal Sex: Male Identity: Female	Insured- State	RI
Elle	28	White	Trans girl, female	Legally male	Insured- public	NY
Skye	28	Japanese American	Trans Woman	Female	Insured	CA
Brittanie	31	Multi-racial/ Filipino & Mexican	Trans woman	Female	Insured	NV
Serena	32	Indian	Trans woman	Female	Insured	VA
Lisa	47	Caucasian/Italian/ Irish	Female	Male	Insured - State	MD
Angel	49	Caucasian	Female	Male	Uninsured	MI
Mary	64	African American	Female	Female	Insured	NY

*Answers for Race/Ethnicity, Gender Identity, and Sex are based the participants self-identification in their own responses.

† Participants were asked the question “what is your sex?” I purposely did not define for them what the term “sex” implied; participants therefore responded at times based on their identity in terms of sex, with their legal sex, and their “assigned” sex.

APPENDIX C:
IRB APPROVAL



EXEMPTION NUMBER: 12-0X29

To: Dorothy Hagen
From: Institutional Review Board for the Protection of Human Subjects, Gerald Jerome, Member *GJ/WP*
Date: Friday, October 21, 2011
RE: Application for Approval of Research Involving the Use of Human Participants

Office of University
 Research Services
 Towson University
 8000 York Road
 Towson, MD 21252-0001
 t. 410 704-2236
 f. 410 704-4494

Thank you for submitting an application for approval of the research titled, *Finding the words: An examination into the Experiences of Transgender Identified Individuals and Medical Service Providers Use of Gendered Language.*

to the Institutional Review Board for the Protection of Human Participants (IRB) at Towson University.

Your research is exempt from general Human Participants requirements according to 45 CFR 46.101(b)(2). No further review of this project is required from year to year provided it does not deviate from the submitted research design.

If you substantially change your research project or your survey instrument, please notify the Board immediately.

We wish you every success in your research project.

CC: P. Galupo
 File

APPENDIX D:

INFORMED CONSENT FORM

My name is Brienne Hagen and I am a Towson University Master's student in the Women and Gender Studies department. I am conducting research to examine the experiences of transgender individuals with their medical service providers. The study is on the use of gendered language within a medical setting, such as medical forms that ask questions about sex and gender as well as in person doctor/patient interactions. The research will provide an understanding of the effect of the use of gendered language. In the study, individual interviews will be performed with transgender identified individuals and with medical service providers who have experience working with transgender patients. Your participation in this study would involve a one time, individual, and in person interview, or if you choose you will have the option to have your interview conducted online through Skype or through email. All participants in the study must be 18 years of age or older. The information collected from this study will subsequently be used in my master's thesis that focuses on the effects of gendered language.

I will be conducting the interviews, which will each take a minimum of one hour with no maximum time limit. Interviews are expected to last approximately 1-2 hours. During the interviews you will be asked to respond to a series of questions regarding your experiences. The interviews will be recorded through a digital audio recorder. The interview will conversation style and informal. You will have the ability to ask any questions you may have throughout the process and decline answering any questions in which you feel uncomfortable. After the interview you will have the option to receive a transcription of your interview if you choose to.

The interview will be completely confidential and you will be given the opportunity to choose your own pseudonym in which you will be referred to in my future thesis. Confidentiality will be maintained during the presentation, publication and dissemination of study results. Your participation in this research is voluntary. You have the right to decline and end participation at any point during this study.

If you have questions at any point of the research process, please feel free to contact the principal investigator, D. Brienne Hagen, graduate student in the Women and Gender Studies Department at Towson University (240-320-3700, dhagen1@students.towson.edu). You may also contact my thesis advisor, Dr. Paz Galupo (pgalupo@towson.edu) or contact Dr. Debi Gartland, Chairperson of the Institutional Review Board for the Protection of Human Participants at Towson University (410.704.2236).

I, _____, confirm that I am at least 18 years of age and have read and understand the above statement and consent to participate in the study.

Date: _____

Participant Signature: _____

Researcher Signature: _____

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Education

2012	M.S. in Women and Gender Studies	Towson University	Towson, MD
	Concentration: Women, Leadership, and Public Policy		
2009	B.S. in Political Science	Towson University	Towson, MD
	Minor in Women Studies: Minor in Lesbian, Gay, Bisexual, and Transgender Studies		

Research Interests

Queer theory, trans* studies, gender non-conformity, the body/fat bodies/embodiment and identities, masculinities, sexualities, disability studies, activist theory, and camp/queer humor.

Publications

Galupo, M. P., Bauerband L. A., Gonzalez, K. A., **Hagen, D. B.**, Hether, S. D., & Krum, T. E. (in press). *Transgender Friendship Experiences: Benefits and barriers of friendships across gender identity and sexual orientation*. *Feminism & Psychology*.

Manuscript (in preparation- expected submission 2012) Bauerband, L. A., Gonzalez, K., **Hagen, B.**, Krum, T. & Galupo, M. P. *Friendships of Transgender Identified Individuals: Experiences of Identity Disclosure*.

Research Experience

2010-12	Research Team Member: Gender Identity and Sexuality Lab, Towson University Project Title: <i>Positive Transgender Experience</i> ; Advisor: Dr. M. Paz Galupo
2011-12	Masters thesis: <i>Talking Gender: Gendered Language Experiences of Trans* Individuals with Medical Providers</i> ; Dr. M. Paz Galupo (committee chair), Dr. Cecilia Rio and Dr. Ayse Dayi (committee members).

Graduate Assistantship

2011-12 LGBT Student Development Program: Center for Student Diversity, Towson University

Presentations (1 of 9)

2012 Working With Trans* Students on the College Campus: Training for Human Resources, Towson University

Teaching Experience

2011 Graduate Teaching Assistant: PSYC: 447 Sex Differences. Towson University

Internship

2009 Transgender Student Concerns Intern: LGBT Student Development Program, Towson University

Scholarship and Awards (2 of 3)

2011	Unsung Hero Award, LGBT Student Development, Towson University
2009	Diversity Program Award, Housing and Residence Life, Towson University

