Queering the Doctor's Office: A Co-cultural Examination of Doctor-Patient Communication

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ABSTRACT

This research examines transgender individuals and their communication with doctors when visiting the doctor's office. A co-cultural theoretical framework was used to identify which communication strategies transgender individuals utilized when interacting with healthcare professionals. In-depth interviews were conducted with 20 self-identifying transgender individuals that had begun the medical transition process (i.e. hormone replacement therapy, surgery, etc.). Results of a thematic analysis reveal that transgender individuals faced several challenges when entering the healthcare context. Data analysis reveals transgender individuals used five particular communication strategies to help them accomplish their healthcare goals.

CHAPTER I

INTRODUCTION

The moment a child exits the womb, the announcement of their sex determines the gender role they are to maintain, represent, and accept. Even when born intersex, physicians determine the gender a child is to follow. Due to the common gender binary system, which positions a person's gender as either male or female (Allen, 2009), most health (and non-health) professionals in the U.S. health system are conditioned culturally to recognize only two genders, a fact that becomes problematic for transgender individuals. Transgender individuals are defined as those persons whose "gender identity or expression does not conform to the social expectations for their assigned sex at birth" (Gressgard, 2010, p. 540). Transgender individuals are confronted with unique challenges when communicating with traditionally dominant group members on a daily basis (or those who identify as White, Middle-Upper Class, Anglo-Saxon, Protestant Males, see Orbe 1998a). Much of the present communication struggle of trans surrounds the historical ways in which trans individuals were positioned throughout U.S. history.

The transgender community has been a misunderstood co-cultural, or traditionally marginalized, group throughout the United States' history (Johnson, 2010; Reis, 2004; Stryker, 2008a; Wenzel, 2007). In addition to being marginalized due to their sexual orientation (Allen, 2009; Orbe, 1998a), trans individuals have been marginalized in the medical community at large. For many years, until 2013, being transgender was listed as an illness of the mind until publication of the fifth edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association, a reference manual

used by health professionals. Today, many transgender individuals continue to experience communication barriers when talking with their doctors simply because of their trans status and the connotations that the status embodies (Aramburu Alegria, 2011; Bockting, 2009; Kenagy, 2005; Ramsey, 1996; Wilkinson, 2006).

A few of the common medical issues trans individuals encounter include locating a doctor willing and able to prescribe hormones, monitoring the correct balance of hormones through blood work, identifying any conflicts between hormone levels and other health issues, and receiving clearance for any type of transition-related surgery, among many others. It needs to be distinguished that trans individuals are indeed different health cases from other cisgender patients. There are commonalities such as hormone levels being controlled for women experiencing menopause or patients being cleared for any type of surgery, such as gastric bypass. However, what sets trans individuals apart is the combination of these experiences along with the frequent misunderstanding of gender identity. Typically, patients experience one of these elements, although gender identity is an issue specific to the trans population.

Framed through Orbe's (1998a) co-cultural theory, this qualitative, interpretive exploration is interested in the health-related, intercultural communication challenges between doctors and transgender patients in the health context, specifically during visits to the doctor's office. This framework positions trans patient and doctor communication within intercultural communication studies. Intercultural communication is an umbrella term to include all aspects of communication that involve perceived cultural difference, including: age, race/ethnicity, abilities, sex, gender, national origin, and/or religion (Castle Bell, 2012; Hopson, 2011; Orbe & Harris, 2008).

Perceived cultural difference indicates the perceptions individuals place on others. A lot of perceptions are primarily based on appearance or past experiences. For instance, a trans individual might perceive a doctor to be uneducated about trans issues based on past experiences with other doctors. Another example would be for a doctor to perceive that all trans individuals want Sexual Reassignment Surgery (SRS) as a part of their medical transition. This is a perceived cultural difference; a doctor does not belong to the transgender culture and therefore, cannot fully understand the community. Intercultural communication can be positioned as consisting of the interplay between values, beliefs, norms, and practices of cultural members during communication interactions or between individuals who share the same space (Castle Bell, 2012; Hopson, 2011). This definition of intercultural communication helps to situate transgender individuals in most environments involving cisgender individuals. *Cisgender* is defined as an individual who has a binary gender (male or female), or is not transgender (Wentling, Windsor, Schilt, & Lucal, 2008). A lot of cisgender individuals are ignorant about the lives of transgender individuals and the common difficulties and challenges they face. Due to this misunderstanding, the communication interactions between cisgender and transgender individuals are intercultural.

In the following section, I briefly review previous trans literature and discuss how this study fills a gap by identifying the ways co-cultural theory is applied to the doctor-trans patient interactions, ultimately benefiting communication studies. Next, I discuss the social significance of this exploration. Lastly, I provide a mutual terminology for this exploration. This chapter concludes by engaging in self-reflexivity and previewing the future chapters to come.

Previous Explorations and Benefits for Communication Studies

Many academic disciplines including sociology, psychology, and communications, among others, have studied transgender culture. Although several topics have been investigated, previous research has not yet explored communication-specific challenges that transgender individuals encounter daily, let alone while visiting the doctor's office. Researchers have explored: a) discrimination (Beemyn & Rankin, 2011; Billings & Urban, 1982; Brown & Rounsley, 1996; Clements-Nolle, Marx, & Katz, 2008; Currah, Juang, & Minter, 2006; Dewey, 2008; Doan, 2010; Gagne & Tewksbury, 1998; Heath, 2006; Keller, 1999; Kenagy, 2005; Kosenko, 2011; Shelley, 2008; Sheridan, 2009; Styker, 2008; Testa et al., 2012), b) healthcare (Aramburu Alegria, 2011; Billings & Urban, 1982; Bockting, 2009; Bockting & Cesaretti, 2001; Budge et al., 2013; Dewey, 2008; Keller, 1999; Kenagy, 2005; Meyerowitz, 2002; Ramsey, 1996; Ross, Scholl, & Castle Bell, 2014), c) interpersonal communication (Bethea & McCollum, 2013; Carroll et al., 2012; Nadal, Skolnik, & Wong, 2012; Riggle et al., 2011; Tamas Futty, 2010; Walch et al., 2012), d) trans as theory-driven (Ackerson & Viswanath, 2009; Ayres, 1979; Baack, Fogliasso, & Harris, 2000; Burke, 1980; Eisenberg, 2001; Maguen, Shipherd, Harris, & Welch, 2007; Mulford & Salisbury, 1964; Nuttbrock et al., 2009), and e) gender fluidity (Bornstein, 1994; Butler, 1990; Clements-Nolle et al., 2008; Doan, 2010; Feinberg, 1992; 1996; Gressgard, 2010; Pusch, 2005).

As evidenced from previous literature, a scholarly examination regarding a trans individual's communicative experiences as non-dominant group members, and the ways in which they use communication to navigate spaces of discrimination while visiting the doctor's office, has yet to be examined. Communication literature will benefit from

exploring the communication between doctors and transgender patients. This study adds to the body of literature in four significant ways in which past research has not: exploration of trans from a communication perspective, patient-provider communicative impacts on individual healthcare, trans individuals positioned as co-cultural group members, and expansion of co-cultural theory.

Adding to Communication, Filling the Gap

First, this study seeks to fill the gap in trans literature by exploring trans from a communication perspective. Carey (1989) defines communication as an exercise by which communication is produced, maintained, repaired, and transformed during the dialogue process. Further, Carey (1989) explains that communication "spreads, transmits, and disseminates knowledge, ideas, and information farther and faster with the goal of controlling space and people" (p. 17). In other words, communication is the everyday interpersonal conversations people hold, both verbally and nonverbally. Communication between trans patients and their physicians therefore functions to produce, maintain, repair, and transform trans patient and doctor communication in the health context. Acknowledging the messages used to communicate and the ways in which verbal and nonverbal communication functions in this space might provide insights relevant for enhancing trans patient and doctor communication.

Second, this study examines the communication between patient-provider as it influences health care for the transgender patient. Specifically, this study looks at the communication with the primary care physician during regular health visits, not primarily related to trans-related medical issues. Health communication, simply defined, is the communication within health contexts (Wright, Sparks, & O'Hair, 2013). Other scholars

might be interested in exploring the medicinal aspects of patient-provider relationships for transgender patients. There is the possibility that specific communication strategies utilized by trans individuals impact the level of healthcare received. Therefore, communication strategies used in other environments, such as interpersonal conversations or family communication, have the potential to impact a transgender individual's life as well.

Third, although previous research has explored trans individuals in these contexts, to date scholars have not yet positioned trans individuals as co-cultural group members and explored their everyday lived experiences from a co-cultural perspective. A co-cultural group is any underrepresented group of people that must consciously enact a number of strategies to navigate interactions with dominant group members (Orbe & Roberts, 2012). Examining trans individuals through a co-cultural theoretical framework will help scholars understand how transgender individuals navigate their social space as non-dominant group members. Adding the element of gender to this setting creates another level of understanding that can be beneficial to scholarly research. For instance, how does a transgender individual negotiate their gender identity as male, female, or transgender, within each interaction? What communication strategies are used in these types of situations? The answers to these questions, if discovered, could help scholars predict the communication behaviors of transgender individuals. It is also possible that framing this study with a co-cultural framework will create change in the transgender community, as well as the cisgender community. This change could include improvements in healthcare experiences for trans individuals or a better understanding of the communication challenges for trans individuals by cisgender individuals. Identifying

the communication strategies used by transgender individuals could shift the way cisgender and transgender individuals act in a given situation together, especially in the health environment.

Finally, this research might help scholars to extend co-cultural theory and possibly apply co-cultural theory in new ways. Since Orbe's (1996) initial establishment of the theory, several scholars have extended co-cultural theory by adding new strategies such as rationalization, speaking out, and intimidation (Castle Bell, Hopson, & Ross, 2015; Harter, Edwards, McClanahan, Hopson, & Carson-Stern, 2003; Orbe & Groscurth, 2004; Orbe & Roberts, 2012; Ramirez-Sanchez, 2008; Urban & Orbe, 2007). It is important that each theory hold a heuristic value in order to further research (Littlejohn & Foss, 2011). This means that individuals should be left asking questions, which can then turn into an extension of that theory. Theory building has multiple benefits including: a) theory building creates a roadmap for other scholars, b) theory building is an organizing framework to classify everyday interpretations, and c) theory building pulls together scholars as a community. Other scholars in similar fields use theories to guide additional research in the same areas (Crotty, 1998; Littlejohn & Foss, 2011). Most new research is inspired by an existing theory, and thus, new research is being conducted continuously by the addition of new theories.

Further, scholars and non-scholars alike can use theory to help interpret everyday problematic matters (Griffin, 2009; Littlejohn & Foss, 2011). This means that each theory addresses a social issue and attempts to explain it in an organized manner, thus helping individuals make sense of the situation. Finally, a scholarly community is fostered through theory building (Littlejohn & Foss, 2011). Whether or not scholars agree or

disagree with a newly developed theory, all scholars contribute to the ongoing conversation that is theory and research.

In addition to benefiting communication research, this exploration is significant from a social perspective as well. The gains extend to the general public, the transgender community members, and healthcare professionals.

Social Significance

This study is socially significant and holds several implications for the general public. First, the transgender community has been neglected in terms of health communication literature and it is possible that because of this, society has a negative, or uneducated, view of the community at large. This study can help to educate society members and therefore decrease the violence and misunderstanding targeting transgender individuals.

Second, this study has social significance for transgender individuals themselves. Healthcare could possibly become an area where the transgender community experiences less or no discrimination. If transgender individuals can start to recognize the communication strategies they use in the doctor's office, they might be able to prevent a bad experience. Moreover, such a revelation might enable trans individuals to learn to better communicate with their providers in such a way that accomplishes their health communication goals. Also, if transgender individuals can adopt a new communication strategy to approach the health environment, it is likely that their experiences will be more positive. It is important to note that the transgender community could potentially start to develop a list of helpful, trans-friendly physicians. The more studies that are done

surrounding the trans community, the less trans individuals might feel like social outcasts or minorities.

Third, health professionals of all specialties can benefit from this research. Transgender individuals, like most members of the general population, require regular visits to physicians, dentists, and optometrists. Transgender individuals however, must make frequent visits when in transition to monitor progress and continue through the steps to present as the preferred gender. The results from this study might provide health professionals with information regarding how trans individual feel when they communicate with doctors. Doctors might learn information, which will enable them to communicate and to provide better care to trans patients. In addition, doctors can become aware of the need for extended education in the area of perceived cultural difference between themselves and their patients.

Finally, this analysis could help to explain the communication behaviors of patients and their providers in the doctor's office. Critically understanding the every day lived experiences trans individuals face when communicating in the health context could positively change the perception and reality regarding the health context for many individuals. From a critical, intercultural perspective, I intend for this project to shed light upon how people can "become sensitive to and responsible for the ways in which difference matters" (Hopson, 2009, p. 6). In light of this critical, intercultural exploration, I aim to provide practical, communicative recommendations that would make the health context a more pleasant experience for all individuals involved, doctors and trans patients alike. Specifically, once the communication strategies are narrowed down, doctors can learn to expect these strategies from their trans patients during their healthcare visits. A

better understanding and an overall expectation of communication behavior can help the interaction to run smoothly with less confusion. Proving such recommendations helps scholars take responsibility for how self-identifying as a trans patient, influences doctor-patient communication.

Mutual Terminology

Moving forward it is important to establish a shared meaning of terminology to ensure ample comprehension. Scholars have made a clear distinction between sex and gender (Allen, 2009; Bornstein, 1994; Wood, 2011). For instance, *sex* can be defined as a function of the body that influences how we develop and it is determined by biology meaning external genitalia and internal sex organs (Bornstein, 1994; Meyerowitz, 2002; Wood, 2011). In other words, *sex* is what we are born, male or female, and *gender* is how we learn to act or express ourselves, as masculine or feminine (Allen, 2009). *Gender* is considered to be the sense of being a man or a woman that we express, as masculine or feminine, and it can be conditioned, imprinted, or learned by society (Allen, 2004; Meyerowitz, 2002, Wood, 2011). *Gender* is therefore accepted as socially constructed and dependent upon the community that surrounds an individual. However, these definitions are not as clear-cut for every person.

For a *transgender* individual, gender can be complicated. For a portion of the population, their assigned sex and therefore gender, do not match. Specifically, *transgender* can be defined as an individual who has a mind/body conflict; an individual that traverses, bridges, or blurs the boundaries of sex and gender by not conforming to the social expectations of the body they were born with because their inner conviction and

mental image of the self does not match (Brown and Rounsley, 1996; Feinberg, 1996; Gressgard, 2010; Meyerowitz, 2002).

Engaging in Self-Reflexivity

For most scholars, their research comes from a place of personal connection or experience. My research is no different. Below I explain where my initial interest in the trans community stemmed. Then I reflect on my personal connection to my research as an androgynous lesbian.

My Friend Ash. Transgender culture has been a personal interest of mine for approximately five years. Much thanks is given to my good friend, Ash, who let me experience each step and some of the details of his transition from female to male with him. For instance, Ash took a daily dosage of multiple pills and a weekly shot of testosterone to suppress the feminine traits he exhibited. After experiencing these changes and processes with Ash, I knew there was more to discover. Since that time, I have dedicated my research and my studies to learning more about the transgender community. The largest discovery I have made is that there is not a grand amount of literature surrounding the transgender community.

The decision to embark upon the transition process is not an easy decision. It requires deep thought and consideration to undergo the consequences of such a profound choice. For example, Ash chose his own happiness over his family's wishes of happiness for him. For about a year, Ash was cut off from his family after he disclosed his transgender identity. On the day Ash told his parents, his dad beat him so hard he was put into the hospital. This violent experience resulted in Ash being diagnosed with Post-traumatic Stress Disorder (PTSD). This is just one example of the kinds of mental and

physical effects a transgender individual can experience when trying to present themselves as their true self. Eventually, Ash and his family reunited and learned to accept one another, despite past and future decisions or actions.

Ash has faced many obstacles throughout his transition, beyond the initial rejection of his immediate family. For example, the pressures of everyday gender expectations consistently serve as a burden to conform. Healthcare, the workplace, the general public, and interpersonal relationships are only a few of the many avenues of transgender culture that are of interest. My hope is to explore all of these aspects, and more, of transgender culture to help educate the general society and improve the behavior and understanding toward the transgender community.

My Personal Connection. This subject is close to my personal story. Although I identify as a lesbian and not as a trans individual, I often times am mistaken for a male due to my personal appearance. Despite having many feminine personality traits, my personal preferences in presentation are masculine. I have a "typical" short, lesbian haircut, I wear men's clothing, I have tattoos, and I have plugs in my ears (meaning I have stretched my earlobes). The way I choose to express myself is simply for the sake of being comfortable. However, a part of me also dresses the way I do to push envelopes. Not only through my research, but also through my appearance I seek to trouble accepted notions of gender.

Out and Proud for Six Years. Overall, I experience support from my immediate family members and close friends. However, I continue to think about my gender presentation and performance on a regular basis. I often find myself nervous to enter the women's restroom because of the reactions I might get from some of the women coming

in and out of the restroom. Many women have approached me to ask if I was in the correct restroom or to even tell me that I was in the *wrong* restroom. If someone questions whether I am a boy or a girl, perhaps their confusion will lead them to the realization that people can be a little bit of both genders—that gender is more of a fluid identity, rather than a binary category. These experiences are what have helped me realize how the world is, versus how it could be, and what I can do to change the gender binary mindset, or at least, to help trans co-cultural community members be more comfortable as they navigate dominant, cultural spaces.

Finally, my experience makes me feel as if I have a sense of connection to an aspect of the transgender community. Like some transgender individuals, I have a hard time blending into society. I struggle to avoid instances of discrimination because of my physical appearance. I also find it difficult when I think about how I break down stereotypical gender images. Even as I write this thesis, I continue to struggle with the formation and ever changing construction of my gender identity. Gender scholars such as Brenda Allen (2004), Kate Bornstein (1994), and Judith Butler (1990) have contributed to the progress already made in terms of how gender is viewed in society. I can only hope that my research will add to this literature and help society shift how it views gender.

Thesis Preview: What to Expect

In the following thesis, chapter two provides a theoretical framework and relevant communication literature. Chapter three outlines the methods used in this project. As a qualitative study, interviews were conducted with transgender individuals across the United States. These interviews were coded and analyzed according to Owen's (1984) thematic analysis. Chapter four explores the themes discovered in the data and analysis.

Finally, chapter five includes the conclusions and implications of this project. This project yields several conclusions and many implications for the transgender and cisgender communities alike.

CHAPTER II

LITERATURE REVIEW

In this chapter, a review of transgender literature is provided. This section begins by establishing a mutual terminology of defining key terms. Next, the origins of the trans community are briefly described. Then, a history of the ongoing discrimination against the trans community is explored. Following, the current understandings of the trans community and experiences of discrimination in the common day are provided. Thereafter, previous areas within transgender culture are explained briefly. Finally, the theoretical framework guiding this study is explained in detail and I demonstrate the application of co-cultural theory to this thesis.

Defining Terminology

Below, a necessary terminology is defined and discussed in order to strengthen a common understanding of the literature. There are three terms that require a mutual definition for which a shared meaning can be created and understood: prejudice, transphobia, and discrimination. Defined and discussed below, these terms are important for the construction of perception for the literature reviewed.

Prejudice. *Prejudice* is defined as the act of "prejudging something or someone based on biased cognitive and affective preconceptions" (Ting-Toomey, 1999, p.164). Prejudice then, is part of individuals' thought processes and involves their affinity for or against individuals or cultural groups (Hopson, 2011). This means that individuals use their prior experiences and ideas to judge someone, whether unfavorably or more favorably. In other words, prejudice can be referred to as holding empathy for or against affiliates of particular cultural groups (Castle Bell 2012). Both of these views, empathy

for and against, are undesirable since they are still elements of prejudiced behavior. For instance, holding empathy for a particular co-cultural member is like feeling the need to help the person because you sympathize with them, whether they ask for the help or not. Since prejudice is a thought process, those who are prejudiced against trans individuals have preconceived thoughts about trans individuals. Individuals whom are prejudiced against those identifying with the trans community can be described as having trans prejudice, while those individuals with an affinity for the trans community could be described as allies.

Transphobia. Also a form of prejudice is the term known as transphobia. Literally defined, transphobia is the fear of trans individuals. More specifically, *transphobia* is "skepticism about the existence of the transsexed or a dislike or hatred of, and occasionally hostility toward, them" (Heath, 2006, p. 15). In other words, transphobia is the dislike of individuals whom identify themselves with the transgender community, members and allies alike. According to Heath (2006), transphobia knows no limits and can move beyond the public into the offices of many professionals, including healthcare. Often in cases where individuals have an affinity against a particular group, this type of prejudice, biased opinion can often lead to violent behavior, or acts of discrimination.

Discrimination. The transgender community experiences a significant amount of discrimination. *Discrimination* includes "verbal and nonverbal actions that carry out prejudices" (Ting-Toomey, 1999, p. 166). While prejudice is the thought, discrimination involves action. Thus, discrimination comprises all of the behavior for which prejudice is the catalyst. Verbally, someone might say offensive things to trans individuals; for instance, using non-pronouns like "it" or "he-she/she-male," or catcalling derogatory

names. Nonverbally, people could stare or glare at trans community members. Also embedded in the definition of discrimination are violent acts against the trans community such as beatings, rape, or even murder.

Now that a mutual terminology has been established, literature regarding the history of the transgender community is explored in the following section. Specifically, an overall history of transgenderism is provided below. In the section to come, I briefly review the historical development of transgenderism from before the nineteenth-century and provide more detail as the nineteenth- twentieth- and-twenty-first centuries are reviewed. Experiences with prejudice and discrimination are provided throughout this historical overview to contextualize the trans experience.

Ancient Transgenderism and An Affinity for Trans

Many people might be under the impression that the presence of transgender individuals is relatively new. This assumption would be correct when considering only the United States. Prior to the nineteenth-century, there is evidence of transsexualism starting in the ancient Greek and Roman eras (Feinberg, 1996; MacKenzie, 1994).

Public perceptions of transgender communities have not always been regarded as negative. In some societies, transgender individuals were celebrated, deemed a descendant of a transgender deity, such as Artemis or Dionysus in Greek mythology (Conner, Hatfield Sparks, & Sparks, 1997; Feinberg, 1996; Heath, 2006). Myriad countries have a past with transgender gods, goddesses, and people in general (Oram, 2006; Stryker, 2008a). Many of these ancient societies "held transgendered people in high esteem" (Feinberg, 1992, p. 206). In addition to being arbitrated in ancient societies, the concept of transgenderism is also prevalent throughout history. Transgenderism

"appear[s] as themes in [Neolithic] creation stories, legends, parables, and oral history" (Feinberg, 1996, p. 43). In addition to these Neolithic societies, the Native Americans also considered transgender individuals, or two-spirited people, a part of nature and valued members of society (Feinberg, 1992, Wolf, 2009). It was not until the twelfth century that trans individuals were viewed negatively.

A Negative Affinity for Trans: History of Discrimination

History of Trans Discrimination. The acceptance of trans individuals into the common society ended early in the centuries with the introduction of discrimination. It is only recently in the twenty-first century that the courts have decided to do something about the continuous discrimination trans individuals face on a daily basis. Minter (2006) explains the vulnerability of trans community members:

> Gender nonconforming people consistently have been among the most visible and vulnerable members of gay communities—among the most likely to be beaten, raped, and killed; among the most likely to be criminalized and labeled deviant; among the most likely to end up in psychiatric hospitals and prisons; among the most likely to be denied housing, employment, and medical care; among the most likely to be rejected and harassed as young people; and among the most likely to be separated from their own children. (p. 142)

From the condemnation by the church in the twelfth century to the nineteenth century riots and raids to the present day, there are several aspects of transgender prejudice and discrimination experienced by the trans community. A few examples of this prejudice and discrimination would include refusal of services in any business, discriminatory slurs, and blatant physical attacks.

The information presented below highlights many areas where an affinity against members of the trans community exist throughout history, including: a) conflict with the Roman Catholic Church, b) trans conflict with society, c) conflict in law protection, and d) passing through the centuries.

Conflict with the Roman Catholic Church: Christianity and the Trans Community. As the general Western society began to develop, Christianity came to the forefront of rule. According to Feinberg (1992), "By the 11th century, the Catholic church—by then the largest landlord in Western Europe—gained the organizational and military strength to wage war against the followers of the old beliefs (p. 212). In other words, those that did not follow suit with the new beliefs established by the Roman Catholic Church were sought out as heretics. Included in this deviant group of people were trans individuals. The historical Roman Catholic Church functioned as a system of hierarchy, merely an overruling institution, focused more on governmental ruling, than the Christian religion itself (Catechism, 4, 877). When the word "Christianity" is used in this historical overview, it refers to the Roman Catholic Church, as it was understood in eleventh century Europe.

According to Feinberg (1992), combined with the emphasis on Christianity, "Transgender in all its forms became a target. In reality it was the rise of private property, the male-dominated family, and class divisions led to narrowing what was considered acceptable self-expression" (p. 211). With the rise of the Roman Catholic Church the trans population has been ridiculed. There is evidence from the sixth- through the thirteenth-centuries of Christians denouncing cross-dressing and transgender expression (Chaline, 2010; Feinberg, 1996; MacKenzie, 1994).

Trans individuals were even among those targeted during the witch trials in previous centuries. It was believed that witches possessed the power to change sex and thus, in 1233 during the Medieval "Holy" Inquisition, the witch trials were used as "weapons of terror and mass murder" (Feinberg, 1996, p. 71). A large number of innocent people were killed during those times. Trans individuals were targets for the Roman Catholic Church and deemed heretics worthy of death (Chaline, 2010; Feinberg, 1992; 1996). The slightest example of trans-related behavior was typically condemned. Anyone who did not agree with the teachings of the church was considered a threat to eradicate; these people included trans people, gay men, some scientists, healers, etc. (Feinberg, 1992). One case in particular is that of Pope Joan. Two separate accounts date Pope Joan's papacy to 1099 and 850 (Chaline, 2010). According to Chaline (2010), Pope Joan went by unnoticed for many years presenting as male, although she was born female. Her femaleness was discovered when in procession and riding a horse, she gave birth. The accounts of her death point in many directions, such as public stoning by dragging of a horse, killed and buried, or that she might have even lived (p. 29-30). The historical church was willing to target anyone and everyone who did not conform. Transgendered behavior was, and still is, considered atypical, strange, and immoral thanks to long-term endorsement from religious and legal positions (Heath, 2006). This derogatory attitude toward transgender individuals stood solid well into the nineteenth century and into the current day.

Trans Conflict with Society. The violence enacted on trans individuals before the nineteenth century typically included murder; however, since murder was made illegal with the coming centuries, society had to divert to other forms of discrimination.

According to Heath (2006), some form of violence is experienced by sixty percent of trans individuals. This is likely because many members of the general public hold a level of transphobia. Many individuals fail to view trans people as people at all, rather, trans people are seen as abject or phobogenic objects and are at a heightened risk of being viewed through a lens of hatred and disgust, which often results in some type of discrimination including violence (Shelley, 2008). Violence is diverse and can take form in many different ways. Namaste (2000) explains:

> I use the term "violence" to refer to a variety of acts, mannerisms, and attitudes. It can range from verbal insults, to an invasion of personal space, to intimidation and the threat of physical assault. "Violence" also includes the act of attacking somebody's body—whether through sexual assault (rape), beating, or with weapons like baseball bats, knives, or guns. (p. 139)

These types of violence, particularly aimed at trans individuals, although still common today, were mostly evident in the early years of the nineteenth century. Events like the Compton's Cafeteria Riot and the Stonewall Rebellion are widely known for the violence enacted by police towards the LGBT community. Due to instances like these, trans individuals are less likely to report incidents of discrimination to the police for fear of misunderstanding or complete disregard (Beemyn & Rankin, 2011). Police often patrolled the gender of society, rather than the actual violence occurring in the streets. Up until the 1980s, all individuals in the United States were legally required to wear a minimum of three articles of clothing belonging to their "biological gender" (Mogul, Ritchie, & Whitlock, 2011). Many trans individuals ignored this law, expressing their gender how they felt necessary. If caught, often in clubs and bars, individuals could be

arrested for false gender impersonation (Mogul, Ritchie, & Whitlock, 2011). Police were and are not the only group of people to show acts of hate.

Many trans individuals experience discrimination from strangers, coworkers, healthcare providers, family members, friends, and supervisors (Beemyn & Rankin, 2011; Meyerowitz, 2002). People tend to fear what they do not know or understand. "[This] gut-level fear can manifest itself as hatred, outrage, panic, or disgust, which may then translate into physical or emotional violence" (Stryker, 2008a, p. 6). Society is not fond of "rule-breakers"; therefore, gender nonconforming individuals are at the most risk of violence or discrimination (Beemyn & Rankin, 2011; Mogul, Ritchie, & Whitlock, 2011; Namaste, 2000; Shelley, 2008). Enactments of transphobia are far more commonplace than many might realize. In fact, violent behavior and hostility is about four times higher for the trans community and on average, leaves one trans person dead every month (Beemyn & Rankin, 2011; Stryker, 2008a).

Trans individuals cannot hide from discrimination; it is in every space—public and private—and any person can contribute. Unfortunately, many trans individuals, such as Brandon Teena and Gwen Araujo, have been victims of rape and murder because of their trans-status (Schilt & Westbrook, 2009; Sloop, 2000). According to Green (2007), "violence and murder are the ultimate insults that all transsexual, transgender, and otherwise gender-variant people are forced to anticipate simply because they exist" (p. 36). When a person's existence, based on a social gender dichotomy, calls for the anticipation of violence and potential murder, there is reason to be concerned with the inequality. Fortunately, activists for the trans community are starting to change the course of history.

Conflict with Law and Protection. Let there be no misconception: there is much room for growth in trans rights. However, steps are being made to ensure protection for trans individuals. Unfortunately, it is still legal in most parts of the U.S. to discriminate based on trans-status (Melendez, 2007), namely in Alabama, New Hampshire, and Wyoming, to name a few. This discrimination is dangerous to trans individuals because it can often lead to physical harm or violence based solely on the fact that they are gender variant. Like most other minority groups, trans individuals need protection from the law to protect their wellbeing. For instance, although the Civil Rights Act was passed in 1964 to protect the rights of racial, religious, and ethnic minorities (Maldonado Jr., 2011), trans individuals were not included in this legislation. As a result, trans individuals must be prepared to handle discrimination in every place they go. All forms of discrimination, no matter the person or the location, can lead to poor physical and mental health (Beemyn & Rankin, 2011). Thus, progress for protection must be enacted.

Even the courts hold anti-LGBT biases and offer no justice or protection for trans individuals involved in court cases (Mogul, Ritchie, & Whitlock, 2011). For instance, the process of legally changing all identifying documents to represent the preferred gender is often a dreadful and time-consuming task for transgender individuals. According to Heath (2006), "transsexed people still suffer from legal inconsistencies that encourage violence towards, and harassment of, transsexed and transgender people" (p. 187). Ultimately, many trans individuals tend to avoid being involved in any quarrels for fear of misguided prosecution or discrimination in places like courtrooms, healthcare, housing, and the workplace (Beemyn & Rankin, 2011; Green, 2007; Melendez, 2007; Mogul, Ritchie, & Whitlock, 2011).

The department of justice (2004) defines a hate crime as "a criminal offense committed against a person, property, or society that is motivated, in whole or in part, by the offender's bias against a race, religion, disability, sexual orientation, or ethnicity/national origin" (p. 65). Although killing someone because they belong to a traditionally marginalized group is positioned as taboo in the United States, trans individuals were not included in the minority groups receiving legal protection for hate crimes. In fact, it was not until 2009 that the federal government officially recognized hate crimes against trans individuals as being unlawful (Beemyn & Rankin, 2011). The killings of Matthew Shepard and James Byrd, Jr., instigated adding gender identity to hate crime provision. This Hate Crimes Prevention Act (HCPA) allowed the Justice Department control over violent crimes committed against persons because of their "actual or perceived race, color, religion, national origin, gender, sexual orientation, gender identity or disability" (Shepard & Byrd, Jr., 2009, para. 3).

Even in the twenty-first century, individuals continue to ridicule and discriminate against trans individuals. For instance, many LGBT youth in public schools experienced so much discrimination; twenty percent reported attempting suicide between 2006 and 2008 (Pierce, 2012). Twenty percent is about five times as much as the heterosexual youth reports, in the same year range. Another example is that of Brandy Martell who was shot and killed while sitting in a parked car in Oakland, CA, in 2012. Many of her friends believe she was shot because of her trans identity (Huet, 2012). A final example of the twenty-first century trans discrimination is the murders of several trans individuals, as reported by Transgender Europe, an organization that tracks and compiles the murders of trans individuals across the world. According to this study by Transgender Europe

(2013), fifteen of the 267 murder cases of 2012 were in the United States and consisted of stabbings, shootings, strangulations, and beatings.

As illustrated in the twenty-first century hate crimes above targeting LGBT individuals, "from the violence on the streets to the brutality of the police, from job discrimination to denial of health care and housing—survival is still a battle for the transgendered population" (Feinberg, 1992, p. 220). Continued progress, both legally and academically, is needed for the misunderstanding of the trans community to dissipate.

Passing Over the Centuries. In response to the growing bias and discrimination against the transgender community, many transgender individuals were forced into hiding, or passing, in order to survive (Namaste, 2000). *Passing* signifies a person who can present as being a particular gender without the "original" sex being suspected (Namaste, 2000)—so a male who passes for female looks so much like a female that the presented female gender identity is not questioned by individuals. Passing was so common in the seventeenth- and eighteenth- centuries that it was the theme for many avenues of entertainment; however, if caught passing, the consequences were violent humiliation or death by burning at the stake (Feinberg, 1992). By the eighteenth century, all of society was following an established system of identity (Oram, 2006). Meaning, the gender binary was established and enforced. Male-born individuals were to be masculine and female-born individuals were to be feminine.

Transgenderism and Science. Eventually, the scientific community became involved in the exploration of the transgender phenomena and began to develop terminology to describe this minority community. To start, Karl Maria Kertbeny officially coined the term "homosexual" in 1869 to describe transgender individuals and

same-sex love (Stryker, 2008a). In 1897, Dr. Magnus Hirschfeld, an influential activist for the GLBT community's liberation, founded and led the Scientific Humanitarian Committee for 35 years in Germany (Feinberg, 1996). Thereafter, Hirschfeld established the Institute for Sexual Science in 1919 in Berlin to study the transgender phenomena.

Unfortunately, the Nazis burned the Institute down in 1933, and a library of more than ten thousand volumes was lost in the fire (Feinberg, 1996; Stryker, 2008a). Hirschfeld's standing contributions to today's transgender community include the separation of sex and gender expression and the term "transvestite," coined in 1910, which is the only word of its kind to survive into contemporary usage (Feinberg, 1996; Heath, 2006; Stryker, 2008a). In 1923, Hirschfeld used the term "transsexualism" to describe the transgender phenomena, in order to acknowledge that gender was not innate, but learned (Heath, 2006; Oram, 2006).

Now that I have explained the history of transgenderism and how discrimination plays a historical role in the trans experience, I discuss how the transgender community came to be known in the United States during the nineteenth century.

Transgender in the United States. Until the mid-nineteenth century many North Americans were not aware of the transgender community's existence. For the United States, transgenderism quickly became something highly misunderstood and unaccepted. This controversy surrounded the debated topic of Sexual Reassignment Surgery (SRS). Christine Jorgenson, although not the first individual to have SRS, became the most legendary transgender person in early U.S. history. In 1952, Jorgenson returned to the United States after having completed SRS and the tabloids made her a star. "[Jorgenson's fame] brought an unprecedented level of public awareness to transgender issues, and it

helped define the terms that would structure identity politics in the decades ahead" (Stryker, 2008a, p. 49). Her physician, Dr. Harry Benjamin, played a monumental part in establishing the history of transgender individuals in the medical field. Treating thousands of patients, he began to call "his gender-variant patients 'transsexuals'" in the late 1950s (Denny, 2006, p. 175). In the 1960s Benjamin published the first book dedicated solely to transgenderism, *The Transsexual Phenomenon* (Stryker, 2008a). Over time, Benjamin developed his Standards of Care (SOC), later adopted and revised by the World Professional Association for Transgender Health (WPATH), formerly known as the Harry Benjamin International Gender Dysphoria Association (Coleman et al., 2011). The SOC are a set of flexible clinical guidelines for hormone replacement therapy and surgical treatment of trans individuals. Despite the progression in the transgender community, prejudice and discrimination persisted.

The U.S. LGBT Liberation Movement Begins. In 1966, the true liberation movement for the entire LGBT community was kick-started by the Compton's Cafeteria Riot. In this riot, the owners of the 24-hour cafeteria called the cops on a group of drag queens, explaining they were "spending more time than money" in the establishment (Stryker, 2008a, p. 64). Shortly after the phone call was made to police, a violent fight ensued between the LGBT inhabitants of the cafeteria and police officers (Stryker, 2008b). Just three years after the Compton's Cafeteria Riot, the Stonewall Riots made news and came to be known as the start of LGBT freedom from suppression.

The Stonewall Inn was a club that many LGBT individuals frequented to be accompanied by those from similar communities (Feinberg, 1992, 1996; Stryker, 2008a). As described by Stryker (2008a), on June 29, 1969, when police raided the dance club

and began detaining many workers and patrons, people in the large crowd that had gathered started to throw coins, rocks, and beer bottles at the police. Thus, a massive fight erupted between the police and over two thousand LGBT people. The rioting continued for four consecutive nights (p. 85). Feinberg (1996) describes the historical riots:

> On that muggy summer night, gay trans anger exploded. The patrons of the bar, and the crowd that gathered, fought back against the police so valiantly that the cops were forced to retreat. The uprising continued for four nights running, and has come to be known as the Stonewall Rebellion (or Riots). (p. 97)

In some senses, the Stonewall Rebellion could be considered "the last straw" for the LGBT community; it "signified the end of a long era of fear and intimidation" (Weiss & Schiller, 1988, p. 67). LGBT people now had more freedom to live in the open air of the general public.

Together, the Compton Cafeteria Riot and the Stonewall Rebellion jump-started a movement for LGBT people, continuing into the present day. Essentially these two historical events mark the moment where trans and other LGB individuals, could come out of the closet they were sanctioned to for almost four centuries. Even with these two major historical events bringing attention and freedom to the LGBT communities, the community struggled with establishing their identity among larger cultural groups. It was not until the 1990s that the term "transgender" came into popularity.

Transgender activists such as Kim Stuart and Virginia Price coined "transgender" in the early 1990s, providing trans community members with terminology from which they were also empowered to avow their own identities (Ekins & King, 2006; Oram,

2006). Transgender came to serve as an umbrella term "for the entire constellation of differently gendered people, including cross-dressers, transgenderists, and transsexuals," among others (Denny, 2006, p. 182). Still today, the term transgender signifies an entire community of people and/or a particular individual who displays gender-variance, something other than female or male.

Current Understandings of the Trans Community: There is Still Work To Do

Even though significant progress has been made on behalf of transgender individuals throughout the country, there is still much work to be done. There are three areas in which specific improvement is needed: a) Assimilation or self-identification, b) medical advances, and c) continued education.

Assimilation or Self-Identification

There are many viewpoints that are consistently debated by scholars. Perhaps one of the largest debates is whether trans individuals should be "out and open" as trans, or if they should "blend" back into the heternormativity that is part of mainstream. Sandy Stone (1991) posits that the highest purpose for a trans person is to "fade into the 'normal' population as soon as possible" (p. 230). Simply put, they should go through the transition process to their preferred gender and then function as that gender in *normal* society. However, Kate Bornstein explains that returning to "normal" after transitioning is not ideal for trans persons. Bornstein associates "becoming normal" with passing; she claims, "passing represents shame, capitulation, invisibility, lies, and self-denial" (Heath, 2006, p. 171). Thus, for Bornstein, the very act of returning to passing embodies a step backwards, towards being closeted, rather than a step forward to being able to freely self-identify as one's preferred gender identity with freedom from prejudice or discrimination.

The transgender community, as its own entity, has started to emerge from the shadows of heteronormativity and now, more than ever, transgender individuals are "demanding the right to choose [their] own self-definitions" (Feinberg, 1992, p. 206). The advances of the transgender community can be attributed to the large number of trans individuals that have remained active in the public eye to promote trans political movements (Heath, 2006).

Whether trans persons assimilate as normal or maintain their trans identities after the transition process, the trans community continues to be a minority group in heteronormative standards. Weiss (2007) explains that ambiguous gender is not accepted well in today's society. Weiss posits that the more people continue to gender-bend, or break the expectations of gender in society by transitioning in some level, the easier it will be for trans people to come out to and live as trans, instead of being forced to gender identify strictly as a man or a woman. Stryker (2008a) reaffirms Weiss's position, maintaining that gender identity is historical, varies by place and culture, and is reliant on several contributing factors. Gender identity is thus, fluid, not statically related to biology. From this fluid perspective, gender will continue to change and alter itself as time passes.

Doctors are often assumed to "know everything," but if that were true, they would have nothing left to learn. This gives good reason for why progress in healthcare in regards to attitudes towards the transgender community has started only recently. In order for doctors to provide the best services to their trans patients, education must be extensive and therefore, will lessen the barriers to trans healthcare. Medical professionals hold the social power to deem what is considered normal or unnatural (Stryker, 2008a). Therefore,

for healthcare providers to show their support through reliable medical treatment is a huge step for the trans community as a whole.

Need for Continued Education

The first Gender Reassignment Surgery (GRS, or SRS) conducted in the United States was in 1931, performed by Dr. Felix Abraham (Heath, 2006; Stryker, 2008a). News of this first surgery on American soil spread rapidly throughout society. Transgender individuals everywhere were looking for a local doctor to perform their own SRS; however their requests were met with major apprehension. The Langley Porter Clinic in San Francisco was a hub for variant sexuality and gender research in the 1940s and 1950s. Dr. Harry Benjamin began his endocrinologist career in 1949 (Stryker, 2008a). Although things started to look up, it took one politician's comment to discourage doctors from working with trans patients. "Genital modification would constitute 'mayhem'" was the statement that deemed SRS to be "the willful destruction of healthy tissue" and thus would open up surgeons to the possibility of criminal prosecution (Stryker, 2008a, p. 45).

This case prevented many doctors from performing any gender-related surgery that would be deemed cosmetic or optional. That is, until Christine Jorgenson's story appeared in the newspapers. Her story caused the medical community to realize that a SRS could properly be performed. With the wide publicity surrounding a successful SRS story, along with the professional relationship between Dr. Benjamin and well-known trans activist Louise Lawrence, the medical community at large saw the possibility of a successful SRS for others as possible.

Benjamin, more or less, set the bar for all SRS surgeries in the United States with his book *The Transsexual Phenomenon*. Healthcare professionals and transgender individuals both followed Benjamin's model, understanding transgender to be the feelings of misery and anguish about the trans individual's identity and self (Denny, 2006). The desire for a medical sex change first came from transsexuals themselves (Oram, 2006). For about a decade, individuals seeking SRS kept pushing on physicians to start performing the genital surgery. Meyerowitz (2002) simplified these interactions:

> In their interactions with doctors, transsexuals dreamed of the new possibilities created by medical science. But as they urged their doctors to enter uncharted territories of medical treatment, they bumped up against the power of medical gatekeepers, the costs of commoditized medical care, and the limits of technology. In response, they learned that only persistence produced results. They needed the cooperation of doctors, but as they applied unsolicited pressure, they and their doctors ended up in conflict. (p. 131)

As medical technology advanced, so did the education of doctors and eventually, their willingness to perform SRS for transgender individuals. This is significant because nearly all steps of a transgender individual's transition are medically related, from access to hormones to surgery. By the end of the 1960s, doctors backed down from their refusal to perform SRS and agreed to "make [transgender individual's] bodies accord with their minds" (Meyerowitz, 2002, p. 167). Finally, transgender individuals were able to seek out SRS to complete their transition.

The first U.S. clinic devoted specifically to gender studies was opened by John Money in 1965 and was located in the John Hopkins Medical School in Baltimore

(Heath, 2006; Stone, 1991). Transgender individuals now had a particular location for which to go and receive SRS, given the financial means to do so. From then, the mid-1960s through the late 1970s was considered the "Big Science" because clinics starting opening at universities across the nation (Stryker, 2008a). These clinics served the transgender population at large. According to Stone (1991), the initial idea for these worldwide clinics stood for two reasons: a) to study the phenomena itself and b) to help people. Unfortunately, these clinics did not stay open for more than a decade. All, if not most, of the developed clinics were closed down, which handed transgender healthcare to private vendors, thus making SRS more available than ever before (Denny, 2006).

In 1980, healthcare professionals deemed transgenderism a new category of psychopathology, and named it a "Gender Identity Disorder" in the fourth edition of the DSM, the reference manual for healthcare professionals (Heath, 2006; Stryker, 2008a). Now, as a listed disorder, trans individuals were able to access transition options with ease. However, treatments were/are not covered by health insurance because they were/are considered elective (Stryker, 2008a). Regardless, trans people deserve the basic care of any human being. They also "require the services of competent health care professionals to facilitate transitioning (if so desired), or to attend to unrelated health concerns or crises" (Shelley, 2008, p 65). As the years pass, trans acceptance and considerations continue to improve. For instance, civil rights protections for trans individuals were established in several cities across the U.S. by the end of 2003 (Denny, 2006).

Although medical progress continues, there exists a strong need for more education about trans individuals in the medical field, including: a) the need for trans

body education, b) the need for trans educated physicians, and c) the need for education to resolve trans health discrimination.

Need for Trans Body Education. A lack of trans education has dominated the medical field for nearly a century or more. Many trans individuals have lodged complaints directly stating their dissatisfaction with the lack of knowledge throughout the medical community. For instance, people reported that their doctors knew very little, were extremely under-prepared, and expressed no interest in learning more about the intricate health needs of the transgender population (Namaste, 2000; Ross et al., 2014; Shelley, 2008). The lack of trans knowledge in the medical community can prove to be detrimental to a trans individual's physical and mental states (Namaste, 2000).

With most health professionals closed to the idea of furthering their own education to include a comprehensive education of the trans body, trans individuals have been forced to research their own physical situation. In fact, health literature reports that many trans individuals know more about their own health needs than their own doctors, thus educating them on their own health needs and sometimes, improving the patient-doctor relationship (Heath, 2006; Namaste, 2000). In order to improve the overall attitude toward the trans community, more trans education is needed (Heath, 2006). However, even if a doctor is knowledgeable on trans healthcare, there is still the barrier of access and cost for trans individuals.

Need for Trans Educated Doctors. Educated doctors on the topic of trans are not always easy to find (Ross et al., 2014). The best doctors typically are in the most urbanized, liberal areas of the United States, such as trans friendly areas like San Francisco (Ross et al., 2014). Unfortunately, there are millions of people who do not live

in California. This means that many trans individuals are subjected to a trans (un)friendly or (un)educated doctor, and thus poor healthcare. Even if a trans individual can get past the first two barriers of the lack of education and the access and cost to healthcare, the most overwhelming barrier to surmount is discrimination.

Need to Resolve Trans Health Discrimination. Discrimination in the health context has played a major role in preventing the trans community from progressing forward. To provide a better quality of care, trans-educated doctors also need to be educated on the topic of trans health discrimination. Just like everyone else in the general society, healthcare professionals carry their own ideals, values, and beliefs, sometimes aligning with their personal religion, about sexuality, which can prevent adequate care for trans individuals (Wimberly & Moore, 2007). As professionals, physicians who possess the ability to set aside their personal stances on such gender identity issues would be appreciated within the trans community; however, literature reveals that there are still those doctors who fail to do so. By adopting this ability, healthcare professionals increase their chances of treating their trans patients with better healthcare resulting in a better experience for the trans individual.

However, many trans people come to loathe their health experiences and some avoid healthcare altogether because of the stereotypical gender concepts typically held by healthcare professionals (Namaste, 2000; Shelley, 2008). The personal beliefs of physicians involved in the care of trans patients can prevent trans individuals in many ways. Transition already presents a considerable amount of stress, but when doctors reject trans individuals, it can push these individuals into unsafe physical and mental spaces. Despite the presence of any personal prejudices, health care professionals need to

serve as a source of education, information, and advocacy for their patients (Wimberly & Moore, 2007). With doctors advocating for their trans patients, it is possible others will learn to accept trans individuals as members of society and not outcasts. Ross et al. (2014) outline three primary recommendations to fostering a comfortable environment for trans individuals. First, asking a trans individual what their preferred name is can be helpful in establishing initial rapport. Second, paying attention to the usage of gendered pronouns is important. Gendered pronouns can make both the trans individual and the cisgender individual uncomfortable if the wrong pronouns are used. Finally, being conscious of gender labeling language is one of the harder tips to which to adapt. For instance, common terms like fireman, saleswoman, and mailman are gender exclusive. Using gender-neutral terms like they, their, or hir[1] in place of he/she and him/her is recommended (Ross et al., 2014).

Although there are many recommendations that can be given to doctors, there are those individuals who will refuse to adapt to the changes. "Providers hold the responsibility of fostering an empathetic atmosphere as well as supplying adequate health treatments to trans patients to make transitioning less difficult" (Ross et al., 2014, p. 8). In some cases, prejudices held by doctors could hinder a trans individual's progress through transition.

Together, the need for trans assimilation and/or self-identification, medical advances, and continued medial education comprise examples of the work still needed to better the quality of life for the trans community. In fact, these educational needs function

[1] Hir (pronounced /here/) is an alternate pronoun that is gender neutral and sometimes preferred by trans individuals (Killermann, 2013).

as health barriers, which pose a significant threat to trans individuals' physical and psychological health (Namaste, 2000).

Co-Cultural Theoretical Framework

In the following theoretical framework, co-cultural theory is defined and discussed in terms of its creation and contents. Then, previous literature utilizing co-cultural theory is explained. Finally, the clarified theory is applied to the current project. Thereafter, the overarching research questions are provided.

The Basics of Co-Cultural Theory. Co-cultural theory is the theoretical framework guiding this analysis. Orbe (1998a) first explained co-cultural theory to help clarify how non-dominant group members communicate with dominant group members. According to Orbe and Roberts (2012), "co-cultural theorizing provides insight into the process that co-cultural group members use to negotiate their 'cultural differences' with others" (p. 294). For the purposes of this study, I am curious how transgender individuals "negotiate their cultural differences," by communicating with their physicians in the doctor's office.

Camara and Orbe (2010) posit that one of the most important reasons for using co-cultural theory as a framework is to understand, "how power strategies are used and how individuals act in response to specific discrimination situations" (p. 84). Therefore, the power at play used in the doctor's office between trans individuals and their doctors is of interest, particularly in terms of discrimination.

Co-cultural theory was founded on the basis of two primary theories: muted group theory (Kramarae, 1981) and standpoint theory (Hartsock, 1984). Each of these theories is discussed below briefly.

Muted Group Theory. Muted group theory (Kramarae, 1981) is based on the concept of a social hierarchy. This theory posits that there is a dominant group within each society that holds a higher social position or status, thus, placing traditionally marginalized or non-dominant group members at a disadvantage (Castle Bell, Hopson, & Ross, 2014). Both dominant and non-dominant group members reinforce this social system of hierarchy, either knowingly or unknowingly. Typically, non-dominant group members respond to the hierarchy by organizing their experiences within this hierarchy because they share the same marginalized position (Ramirez-Sanchez, 2008). Muted groups are deemed to be unacknowledged and unimportant, compared to the dominant culture. Therefore, because of the discourse the dominant culture establishes, muted groups often have no voice in society because they are atypical (Hogg & Reid, 2006). Muted group theory helped provide the theoretical foundation for the construction of co-cultural theory and illustrates how marginalized groups negotiate status within a dominant society. As a muted group, trans individuals are stripped of their voice within the dominant society of health care professionals. Both trans individuals and health care professionals continuously reinforce the social hierarchy of dominant and non-dominant groups. Through muted group theory as a framework for co-cultural theory, trans individuals negotiate their status in society.

Standpoint Theory. Standpoint theory (Hartsock, 1984) is concerned with the idea that individuals use their lived experiences to place themselves within the social world. Burnett et al. (2009) put it best when describing standpoint theory; these scholars are "concerned with recognizing the plurality of human experiences and truths, while recognizing that knowledge and perception are structured by power relations" (p. 468).

Essentially, standpoint theory takes into consideration the diverse experiences individuals hold in order to correctly place each individual into the social hierarchy system. Further, all understandings of a situation need to be considered as depicting an independent point of view (Cohen & Avanzino, 2010). For co-cultural theory, standpoint theory provides a lens for which to look through when acknowledging power relations in social hierarchy and the ways that non-dominant groups members come to understand their experiences. Trans individuals have many experiences that are unique to just trans individuals. How they interpret these experiences determines their standpoint. The perceptions imposed by society also aid in the decision of a standpoint for trans individuals, which is typically that of a minority or non-dominant group.

Primary Concepts of Co-Cultural Theory. Co-cultural theory has developed significantly since Orbe's initial (1996) article, which named 12 co-cultural strategies. Orbe (1998a) presented 26 communication strategies in his book, that help explain non-dominant group member communication with in-group and dominant group members. Today, there are a total of 36 co-cultural communication strategies employed for this purpose (Castle Bell et al., 2014). In addition to these communication strategies, there are also three communication-preferred outcome behaviors as well as three communication approaches to interactions. Finally, there are six influential factors that help determine how a co-cultural group member will react in a given situation with a dominant group member. Each of these elements is discussed below.

Communication Strategies. After Orbe's (1996) exploration of co-cultural strategies, Orbe (1998a) identified 26 communication strategies to help describe the common ways in which underrepresented group members communicate with dominant

group members: emphasize commonalities, develop positive face, censoring self, averting controversy, extensive preparation, overcompensating, manipulating stereotypes, bargaining, dissociating, mirroring, strategic distancing, ridiculing self, increasing visibility, dispelling stereotypes, communicating self, intragroup networking, using liaisons, educating others, confronting, gaining advantage, avoiding, maintaining barriers, exemplifying strengths, embracing stereotypes, attacking, and sabotaging others. Over the years, ten communication strategies were added: self-interrogation, checking yourself, isolation, speaking out, remaining silent, journaling, intimidation, showing appreciation, reporting to authorities, and leaving the situation (Castle Bell et al., 2014).

Ultimately, each one of these communication strategies aids a co-cultural group member to negotiate communication situations with dominant group members. As a co-cultural group, trans individuals likely use these communication strategies to navigate the interactions with their healthcare professionals. The communication strategies listed above are only examples of the accompanying communication outcome behaviors and communication approaches to any given situation (Camara & Orbe, 2010).

Outcome Behaviors. Each of the 37 communication strategies is grouped into one of three primary goals: assimilation, accommodation, or separation. In other words, individuals will adapt to the dominant culture (assimilation), acculturate to the dominant culture (accommodation), or resist the dominant culture altogether (separation). Each of these outcome goals is briefly defined here. In essence, assimilation occurs when the non-dominant group member conforms to the group norms of the dominant group. When non-dominant group members attempt to learn the culture of the dominant group members, while holding their own beliefs at heart, accommodation happens and the result is a co-

cultural experience. Finally, separation occurs when the non-dominant group member rejects the social norms of the dominant group and attempts to establish a space for the norms of their non-dominant group. Co-cultural members select communication strategies based on these three preferred outcome goals.

Communication Approaches. Based on individuals' preferred outcome goals and the selection of co-cultural strategies, co-cultural members employ one of three communication approaches when communicating with dominant group members: assertive, nonassertive, or aggressive communication. When utilizing a *nonassertive* approach, individuals make their personal wants and needs secondary to others' wants and needs. Juxtaposed to a nonassertive approach is the aggressive approach. When an individual enacts an *aggressive* approach, she or he uses selfish motives by placing his or her wants and needs above all others. Falling in between this binary is the *assertive* approach, where the wants and needs of all individuals involved are considered to create a balanced satisfaction when using the assertive approach.

Influential Factors. Finally, in addition to the 36 communication strategies, the preferred outcome goals (assimilation, accommodation, separation), and the communication approaches (nonassertive, assertive, aggressive), there are four influential factors which impact co-cultural members decision to employ one of the 36 strategies: field of experience, perceived costs and rewards, abilities, and situational context.

First, *field of experience* describes the influence of past experiences to shape the interpretation of a co-cultural interaction. Thus, field of experience can determine the choice in communication strategy. Second, *perceived costs and rewards* denote the learned experience of what communication strategies reveal a reward or a cost

(Matsunaga & Torigoe, 2008). In other words, based on trial and error, individuals learn which strategies work best in particular situations. Third, *ability* refers to the accessibility of the communication strategies to each individual. Thus, to enact a communication strategy, one has to be able to do it. Some co-cultural group members are restricted to some strategies based on their individual, social, and organizational abilities (Matsunaga & Torigoe, 2008). Finally, *situational context* describes the situation within which the individual is using a communication strategy. The situational context can include the physical environment, the individuals present in that particular setting, and any contributing circumstances (Orbe & Harris, 2008). It is through the situational context that an individual determines whether or not the communication strategy used is appropriate.

Previous Co-Cultural Literature. Several traditionally marginalized groups have been analyzed using co-cultural theory. Some of these co-cultural groups include: minority races (Buzzanell, 1999; Darity, Royal, & Whitfield, 2010; Gates, 2003; Hardimon, 2013; Miura, 2001; Parker, 2003), sexual orientations (Chance, 2013; Chapman, Zappia, & Shields, 2011; Kama, 2002; O'Hara & Meyer, 2003; Orbe, 1996), (dis)abilities (Fox, Giles, Bourhis, & Orbe, 2000; Orbe & Greer, 2000), and women (First & Lev-Aladgem, 2000), among many others. Co-cultural theory helps to explain the communication behaviors of co-cultural groups, such as the ones listed above.

Theoretical Application

As a co-cultural group, the trans community likely is to enact any number of communication strategies, by employing one of three communication approaches (assertive, nonassertive, or aggressive) when speaking with their doctor to accomplish

one of three communication goals (assimilation, accommodation, or separation). It is the goal of this study to discover *which* communication strategies trans individuals employ in the doctor's office in order to better future physician visits for trans community members. Therefore, the first research question is presented:

> **RQ1:** As a co-cultural group, how do transgender individuals navigate communication interactions with their healthcare providers?

Further, once the communication strategies and communication approaches used by trans individuals in the health context are identified, this study seeks how each of the strategies is used. There are multiple ways in which trans individuals can use each strategy and communication approach. Different interactions within the health context can call for various strategies and approaches. Thus, the second research question was developed:

> **RQ2:** How do transgender individuals employ co-cultural strategies and communication approaches with healthcare professionals in the doctor's office?

CHAPTER III

METHODOLOGICAL FRAMEWORK

This chapter presents the methodological framework for this project. Included in this chapter are the methodological approach, the study sample and sampling technique, data collection and data analysis methods, and finally the qualitative forms of proof.

In the following section, I discuss the methodological approach to this project using an interpretive, critical, qualitative lens. Next, my study sample is briefly described and then the sampling technique is explained. Then, the methods for data collection, namely interviews, are discussed. Thereafter, methods of data analysis, thematic analysis, are described in detail. Finally, the qualitative forms of proof used in this project are presented and the chapter will conclude.

Methodological Approach

This project adopted an interpretive, qualitative approach to examining a critical, intercultural topic: trans co-cultural communication with healthcare providers. Essentially, everyday lived experiences were shared in interpersonal interviews and were then interpreted into categories of meaning. Below, the interpretive, critical, and qualitative research approaches are explained in detail.

First, interpretive research is the basis of qualitative inquiry and surrounds the concept of understanding participants everyday lived experiences, from their perspective (Lindlof & Taylor, 2011). Interpretive research seeks to understand the communicative behaviors and sense making of individuals through their cultural experiences within a social context (Creswell, 2012; Crotty, 1998; Maxwell, 2013). Interpretivism comes from a postmodern perspective, which illustrates that meaning and/or truth are subjective.

Instead, individuals can hold different meanings and see many scientific truths because individuals hold their own interpretation of a situation or concept. However, all interpretations surround the same idea of a cultural experience and the process involved in managing these experiences.

This project also represents a critical approach. Critical research is grounded in a change of any given situation and wedded to practice (Crotty, 1998). It is not enough to think critically; one must also act critically. The critical approach analyzes a culture or setting with the intent of discovering a way to create change in the general society. The need to reduce the level of difference between others and ourselves is inherent (Crotty, 1998). We want to feel closer to those we encounter, so we attempt to close the gap of misunderstanding by trying to see the world from the perspective of the other person. This project is critical because it seeks to understand the cultural experiences of transgender individuals and create a base of knowledge from which others can learn and grow. The agent of change is present in this project because it wants to change the views, beliefs, and assumptions about the transgender community within the healthcare context. In order to approach this project with a critical, interpretive lens, a qualitative research method is best.

Qualitative research is the best approach for this topic because it yields the most information possible, from which valuable information can be sifted. In qualitative research, the researcher serves a primary role in data collection by studying the meaning, representing the views and perspectives, considering the contextual conditions, and contributing insights to understand and explain human social behavior (Yin, 2011). It is important to go for the particular information, rather than the general information because

it is unlikely the stories and experiences told by trans individuals can be generalized to the entire trans population. Researchers document first-hand accounts with individuals of a given population, typically in interpersonal interviews, to gather conclusions of a given topic. As a researcher I interviewed several self-identifying transgender individuals on the topic of healthcare to draw conclusions on the better portion of the population in the healthcare context. Qualitative research, unlike other methods, utilizes multiple sources of information for narrative data (Yin, 2011). This means there are several interviews conducted to help expand the diversity of experiences and interpretations, versus handing out one survey, for example. Accessing multiple people from varying backgrounds significantly contributes to the generalizability of the conclusions from a project.

Study Sample

The sample consists of 20 self-identifying transgender individuals. All individuals were at least 18 years old and came from varying ethnic backgrounds and genders. Individuals were able to participate in this study if they meet three criteria: a) if they were 18 years or older; b) if they self-identified as being a trans individual; and c) if they visited a physician at least once, before, during, or after the start of their medical transition process.

I chose to interview only trans individuals, instead of doctors in addition to trans individuals, for three reasons: a) the experiences of trans individuals, versus their doctors, were more suited to the theoretical framework of this study; b) gaining access to interview doctors would have taken more time than allotted for this project; and c) the number of trans individuals in the U.S. outweighs the number of doctors that treat trans

individuals. I was more concerned with the stories of trans individuals as they experienced their healthcare, uniquely as trans individuals.

Of the total 20 participants, I interviewed nine MTFs (Male-to-female) and ten FTMs (Female-to-male). One participant identified as bi-gender and had no intentions of seeking a medical transition. Although individuals who identify as bi-gender are an important community worthy of research, such an inquiry is beyond the scope of this project. Therefore, no information was gathered that could add to the data collection. The ages of the participants ranged from 20 years old to 70 years old, with an average age of 36. Participants represented five geographic locations including North Carolina (three participants), Texas (twelve participants), Washington state (four participants), New York (one participant), and California (one participant). Of the fifteen participants who reported an estimated annual income, the range was between less than $5k and $200k. The large gap in difference of estimated annual income could be attributed to nine of the twenty participants identifying as students at varying colleges and universities.

From the nine MTFs, all of them had at least started Hormone Replacement Treatment (HRT) and the time span ranged from four months to three years. One participant had undergone hair removal and SRS and another had her SRS scheduled. Of the ten FTMs, all ten were on HRT with a time span of one month to ten years. Half of the FTMs had completed top surgery and two had a hysterectomy.

Sampling Technique

Transgender individuals can be particularly difficult to find when conducting research concerning the population. Due to the sensitive nature of this topic, snowball and convenience sampling are probably the best combined sampling techniques for

recruiting participants. Study participants were collected via a snowball and a convenience sampling technique.

Snowball and Convenience Sampling. Convenience sampling involves utilizing participants the researchers find most convenient and readily available to participate in the study (Keyton, 2011; Lindlof & Taylor, 2011). In other words, most participants will come from a personal connection with one author, making the participants convenient to locate and access. Convenience sampling started this project and from there, snowball sampling was employed to help grow the diversity of participants according to age, gender, geographical location, and/or race, among other demographics. Snowball sampling technique occurs when the researchers rely on participants to contact others they might know that fit the sample description and would be interested in being a participant (Keyton, 2011; Lindlof & Taylor, 2011). The ideal outcome is for each recruited participant to refer a few people they know to the study and the sample size grows like the snowball. Since the transgender community can be challenging to locate, snowball sampling is best, paired with convenience sampling, because the chances of a larger sample size are great. Saturation is an important part of qualitative research to ensure the highest volume of valuable data is collected. Saturation occurs when new categories and themes cease to emerge, and there are mainly repetitions and redundancies in the themes that do appear (Strauss & Corbin, 1990).

To employ snowball and convenience sampling, I began recruiting participants by speaking with individuals I already knew. I interviewed these individuals first and then continued recruitment through those primary individuals. Thus, to use convenience sampling, I started interviews by talking to a trans individual who is readily available,

whether through proximity or because I knew someone who self-identifies in this manner. It was my goal that the convenience sample would then snowball as each participant referred another. Although not every participant recommended other participants, I did have a few participants recruit several others by forwarding an information sheet I had sent them previously, which briefly explained the study (see Appendix A). These participants, recruited via snowball sampling, emailed me with expressed interest in the study. Once I received an email from a potential participant, a recruitment letter (see Appendix B) explaining the study, its procedures, and its requirements was sent via email. The potential participants who came from the convenience sample were also sent the information sheet to then forward to other potential participants, who were given my contact information. Once they contacted me, we worked together to set up an interview day and time.

Strengths and Weaknesses. Using convenience sampling has many strengths and weaknesses. One of the strengths of using convenience sampling is that the study can continue in a prompt manner, accessing the people within the closest parameter. It is important that a project be conducted according to a schedule to ensure the project can be completed within a fair amount of time (Creswell, 2009). Utilizing the qualified participants in the closest distance to the researcher increases the chances of a complete project in the shortest amount of time possible. Another strength in using convenience sampling revolves around the idea of building rapport. The researcher is less likely to need to develop rapport with participants if they already know him/her/hir well. Even more, less rapport is required through snowball sampling because there is already a

connection and level of trust made between the convenient participant and his/her/hir referrals. This concept is referred to as a bridge or liaison (Silverman, 1993).

A disadvantage to using convenience sampling is the sample might not be as diverse. This is a challenge because with a diverse sample, more demographics can be represented, such as age, race, and social economic status. For instance, geographical location can play a major part in the diversity of a sample. By using convenience sampling, the researcher might only have access to a particular age group, race, occupation status, or gender, among others, thus limiting the analysis results. Fortunately, this study had a diverse study sample with ranges in age, race, occupation, and gender (see study sample description on page 56).

Data Collection Methods

In the following section several areas are explored. First, a description of how rapport was developed before, during, and after all of the interviews is given. Next, the method of qualitative interviews is explained and the rationale behind using this particular approach. Then, the construction of the interview guide used in each of the interviews is illustrated. Finally, all steps taken to ensure the confidentiality of all participant information are described.

Developing Rapport. Due to the sensitive nature of this topic, rapport is vital for providing participants a space within which they can share vulnerably. According to Lindlof and Taylor (2011), some research topics can be difficult to discuss due to the vulnerable nature of the topic. For instance, discussing topics such as discrimination, gender, or instances of violation can be difficult for some individuals. Therefore, researchers will be more likely to encourage more information sharing when they

approach the topic carefully, with an attitude of concern. This essential part of data collection is known as developing rapport. In this sensitive study, I first attempted to build rapport at the beginning of the interview to reduce any anxiety or nerves for the participant. Thereafter, I thanked the participant, and briefly explained the purpose and goals of the study and asked them if they had any questions before we began. Next, I shared what participants could expect throughout the interview. I told them the topics surround their experiences as a trans individual and I was interested in their answers and they could feel comfortable sharing. I strived to maintain rapport throughout the interview by displaying positive, encouraging nonverbal communication cues, like leaning-in, nodding, and utilizing back-channel cues that showed appreciation. Then, I reminded interviewees that questions would be asked about trans patient-doctor interactions. Next, I shared that some of the questions might be uncomfortable, but that honest thought about experiences were sought after.

To continue with rapport, participants were also debriefed after the interview. During the debriefing period, I thanked the participants for sharing their stories so openly and reminded them that their sharing was appreciated. Next, I asked the participants if they had any questions that I could answer for them about the interview or the process. I also notified participants that because I appreciated talking with them, I may want to contact them again in the future to discuss the results with them, to make sure I understand and represent their perspective well. I asked for their permission to do so.

Finally, I asked the participants if they knew of anyone whom they thought might like to participate in the interview. If they did, I asked them to email the potential contact my information sheet including my email and phone number.

Interviews. The method of data collection for this project involved interviewing 20 individuals. Interviews are helpful for yielding knowledge and comprehension about the research questions under investigation from the participants' perspectives (Maxwell, 2005). Moreover, interviews also enable participants to play a vital role in the data collection process, by inviting them "to share their stories, examine their lived experiences, and discover information in such a way that makes participants co-researchers in creating meaning" (Castle Bell, 2012, p. 53-54). This study focused on trans individuals' lived experiences with doctors in a health communication context. Interviews carve space for conversation around such a sensitive topic (Creswell & Miller, 2000; Maxwell, 2005). Some of the interview questions cover topics that can be perceived as relatively personal and sensitive. All participants were given the opportunity to pass or choose not to answer any question throughout the interview.

Interview Context. I conducted 20 interviews in one of three formats: a) face-to-face, b) through Skype or FaceTime or c) over the phone. Each of these interviewing formats has benefits and disadvantages.

First, face-to-face interviews were the preferred method for interviewing in this thesis project. Face-to-face interviews yield participants the optimum level of comfortableness for the interview. By giving participants the option of choosing the time and location of the interview, they are more likely to offer more in-depth information in the actual interview (Lindlof & Taylor, 2011). Conducting a face-to-face interview ensures the researcher that the time is protected and the participant is dedicated to that time and place for the given amount of time. Another advantage of face-to-face interviews is the ability to record visual cues such as facial expressions, gestures, and

body postures (Lindlof & Taylor, 2011). These nonverbal actions contribute to the understanding and interpretations of the participant's responses. A possible disadvantage to face-to-face interviews is narrowing down a protected time and a protected location for both the researcher and the participant. If each of these individuals has an active schedule, it can be difficult to figure out a time and location convenient for both individuals. Another disadvantage to face-to-face interviews is the accessibility of qualified participants. Of the twenty interviews conducted, three of them were face-to-face. Dependent upon the type of sampling technique, participants might be specifically chosen for a study and the location of these participants might be far enough to warrant a video or phone interview.

Second, interviews conducted through Skype or FaceTime are advantageous for the reason of nonverbal communication. When face-to-face interviews are not possible, mainly due to location, video chat interviews are second best. Interviews are better conducted when the researcher can see and adapt to the nonverbal communication behaviors displayed by the participants. Nonverbal communication helps the researcher direct questions, detect anxiety, and use probes to find out more information that would otherwise not be known. A disadvantage to using Skype or FaceTime to conduct interviews is that of everyday technology issues. A couple of the interviews did suddenly end because of technology glitches, or certain answers could not be heard clearly. In the case of a dropped Skype call, I called the participant back and continued with the interview. If the Skype call was no longer possible the interview was completed via phone. When participant's answers were unclear, I asked them to repeat their statements. Fifteen of the twenty interviews were conducted via Skype or FaceTime. There is also the

potential that participants might not have access to a video chat and therefore, a phone interview was used.

Finally, phone interviews are used as a last resort to interviewing methods. Phone interviews can be beneficial if it is impossible to meet face-to-face or by video. A phone interview can be conducted at any time, without any extra steps, other than to exchange phone numbers. Although convenient, phone interviews have several disadvantages. One disadvantage to conducting phone interviews is that the researcher is unable to read the nonverbal cues given by the participant. As mentioned before, nonverbal cues are beneficial to probing questions to access more information. Another disadvantage to phone interviews is the possibility of dropped or lost calls. Like video chats, phone call interviews can also end abruptly, disturbing the interview protocol. Lastly, phone interviews cannot guarantee the participant is not multitasking (Lindlof & Taylor, 2011). Researchers would hope that participants are dedicating their full attention to the questions being asked and the answers they are giving, however, phone interviews cannot yield this type of reassurance. Only two interviews needed to be conducted via phone in this study.

With the strengths and weaknesses of conducting interviews over Skype, FaceTime, and the phone presented the benefits to being able to interview 20 people in this co-cultural population outweighs the potential disadvantages presented above.

Constructing the Interview Guide. To conduct interviews, I used a semi-structured in-depth qualitative interview guide. A semi-structured interview guide is one that gives a general list of questions on varying topics related to the subject being studied (Keyton, 2011; Lindlof & Taylor, 2011; Yin, 2011). The guide presents questions to be

asked, but only serves as a guide, not a rigid format. This means that some questions can be changed, shifted, or avoided throughout the interview depending on the direction of the interview. It is beneficial for qualitative interviews because it allows participants to openly share thoughts and opinions, while researchers have the ability to adjust the interview according to the conversation type (Lindlof & Taylor, 2011). Semi-structured interviews help to give a framework to the interview, without demanding a particular protocol for each individual interview. Another reason a semi-structured interview schedule is ideal is because it enables researchers to ask additional, unplanned follow-up questions, which might not have anticipated when developing the questions (Patton, 2002). The questions gathered in the semi-structured interview guide were formed using co-cultural theory literature (Camara & Orbe, 2010; Castle Bell et al., 2014; Orbe, 1996; Orbe 1998a; Orbe & Greer, 2000; Orbe & Groscurth, 2004; Orbe & Harris, 2008; Orbe & Roberts, 2012; Orbe & Spellers, 2005; Urban & Orbe, 2007). The specific, planned questions on the interview guide are provided in Appendix C.

Confidentiality. Participation is completely confidential. During the interview, participants were never asked to reveal their identity. To facilitate privacy, before audio-recordings, participants were invited to select a pseudonym. Using an alias is important as it allows participants to feel their confidentiality has been and will be kept throughout the research process. I kept a key, detailing who the interviewees were and their chosen, or given, alias. To maintain privacy, until all data analysis was complete, all digital recordings, transcriptions, and other identifying documents were kept in a locked file cabinet. A password-protected computer was also used to secure their information. Only

the researchers had access to the study information. Once data analysis was complete, all digital recordings, transcriptions, and other identifying documents were shredded.

Data Analysis Method

The method of data analysis for this project utilized is thematic analysis. Thematic analysis was conducted once the interviews were fully transcribed. The goal of thematic analysis as a data analysis method is to find common themes across all interviews that demonstrate the interconnectedness of the study (Creswell, 2009). Thus, thematic analysis aids the author to locate the significance and information worth sharing in the entire project. Common themes reflect generalizable conclusions of a population based on the sample data collected. The thematic analysis coding process involved reading through each interview carefully several times to locate the underlying meaning of the data. In this project, I followed two types of thematic analysis: Braun and Clarke's (2006) procedures for thematic analysis and Owen's (1984) thematic analysis.

Braun and Clarke. First, I followed Braun and Clarke's procedures to help familiarize myself with the data and to help identify themes and subthemes (Castle Bell, 2012). Although qualitative data analysis is not linear, many of these steps can be conducted more than once and out of this order. Braun and Clarke (2006) provide a six-step process to conducting thematic analysis. First, the researcher must become familiar with the data by transcribing, reading, and re-reading the transcripts. Second, initial codes need to be generated by noting interesting features of the data in an organized way. Third, the researcher should search for themes by organizing the initial codes into potential themes. Fourth, the potential themes should be confirmed by checking for consistency with the established codes. Fifth, the themes should be defined and named. Finally,

producing the report involves identifying the exemplars of each theme and relating them back to the original research question(s) and literature (p. 87).

Owen. Next, to narrow themes into theory and theme driven categories, I utilized Owen's (1984) thematic analysis. Owen's (1984) thematic analysis uses repetition, recurrence, and forcefulness to identify the categories relevant to the study. *Recurrence,* involves observing two reports that have the same thread of meaning (Keyton, 2005). *Repetition* refers to "the duplication of key words and phrases" (Keyton, 2005, p. 41). Finally, *forcefulness* refers to being "attentive to vocal inflections and dramatic pauses that stress or subordinate some utterances" during communication (Keyton, 2005, p. 41). Forcefulness occurs when "participants vocally emphasize certain words and phrases" (Castle Bell, 2012, p. 58). In this study, forcefulness was marked throughout the interview transcriptions by italics, exclamation points, and marked pauses in response.

Qualitative Forms of Proof

After the transcriptions were analyzed, the data results were verified with ten percent of the participants who were interviewed because they identify as being in the trans community. After completing all interviews, transcriptions, and data analysis, the researcher engaged in two forms of qualitative proof: a) member checking and b) respondent validation. Below, each of these forms of proof are defined and explained. Then, the reasoning for utilizing qualitative forms of proof is reviewed. The researchers seek to be mindful of their perspectives "in contrast to the perspectives of and voices of those" interviewed and/or observed (Patton, 2002, p. 299; Silverman, 1993). To accomplish this, member checking and respondent validation is employed.

Member Checking. *Member checking* involves asking members of the population who were not interviewed about their thoughts regarding study results. This process helps to interpret findings and clear up researcher (mis)understandings (Creswell, 2009; Silverman, 1993). Approximately two trans individuals that were not interviewed were approached for member checking. Individuals were chosen based on convenience to the researcher, meaning location and previous relationship.

Respondent Validation. *Respondent validation* occurs when researchers talk to interviewees about study results (Castle Bell, 2012). Clarifying participants' perspectives is beneficial for being certain that the researcher is not imposing his/her/hir own viewpoints on the data (Castle Bell, 2012; Maxwell, 2005; Patton, 2002; Silverman, 1993). Approximately ten percent, or two participants, were approached for respondent validation. The purpose of both follow-up phases is to verify the findings with the participants and to check researcher perceptions.

Reasoning for Forms of Proof. Researchers use qualitative forms of proof to be sure the study results accurately reflect participants' perspectives instead of present only what the researcher sees. Part of engaging in forms of proof requires engaging in researcher perception checking, which is helpful for a few reasons. First, it helps to prevent researcher bias. Researcher bias, or selective observation, is when a researcher sees what they want to see (Creswell, 2009; Yin, 2011). Basically, utilizing forms of proof avoid the researcher from cherry-picking information to make their study meaningful.

Second, a lack of legitimacy is avoided by utilizing qualitative forms of proof. Qualitative research is often considered one of the lesser methods of research because it

was developed as an alternative to the positivistic way of thinking (Lindlof & Taylor, 2011). It was not until the 1990s that communication scholars truly adopted a qualitative approach claiming that the positivist and quantitative methods of inquiry were "insufficient for the study of situated and reflexive social action" (Lindlof & Taylor, 2011, p. 9). Thus, qualitative research advances a focus on specific phenomena surrounding the relationships between power, knowledge, and discourse that reveal themselves in instances of historical and cultural hardship (Lindlof & Taylor, 2011; Maxwell, 2013). Qualitative researchers have begun to enhance the credibility and integrity of their studies by guaranteeing their reports are honest and true. Qualitative forms of proof are a part of the building blocks to this platform of respect.

Finally, qualitative forms of proof support accurate interpretations of social scientific and interpretive research (Crotty, 1998; Silverman, 1993). Social scientific and interpretive research are based heavily on the assumption that humans have patterns of messages and behaviors through which they interpret the social life world, and those patterns can be uncovered through qualitative research (Crotty, 1998; Keyton, 2009; Maxwell, 2013). These patterns are ways of understanding and explaining the everyday events that occur. Further, interpretive research attempts to synthesize the cultural and historical experiences of individuals by co-creating knowledge with participants through interpretation (Creswell, 2009; Crotty, 1998; Maxwell, 2013; Silverman, 1993). Explanations of how the world works around us can be identified, thus making it beneficial for everyone in learning how to approach each unique situation.

CHAPTER IV

DATA AND ANALYSIS

The examples provided by trans individuals below illustrate everyday communicative challenges this community faces in a healthcare environment in the United States. The everyday lived experiences of trans individuals in healthcare provide an opportunity to understand how they communicate with healthcare professionals about their health. From the narratives provided, we can learn the factors of healthcare that are important to the trans participants and attempt to develop more education surrounding trans healthcare as a whole. Trans participants communicated that they experienced many communication challenges when interacting with their healthcare professionals. Data analysis reveals seven major themes and fifteen subthemes. Specifically, the major themes are: a) The Concept of Passing, b) Overall Healthcare Goals, c) Location Matters, d) Co-Cultural Strategies, e) Incompetent Doctors, f) "Good Doctors are Good and Bad Doctors Suck," and g) Advice for Doctors.

The first major theme did not have any subthemes; however, exemplars are provided. The second major theme, Overall Healthcare Goals, had two subthemes: a) Helped and b) Hindered. The third major theme also had two subthemes: a) Advantage and b) Disadvantage. The fourth major theme, Co-Cultural Strategies, had five subthemes: a) Emphasizing Commonalities, b) Communicating Self, c) Rationalization, d) Maintaining Barriers, and e) Educating Others. The fifth major theme did not have any subthemes although exemplars are provided. The sixth major theme had two subthemes: a) Bad Experiences and b) Good Experiences. The major theme name, "Good Doctors are Good and Bad Doctors Suck" was derived directly from participant's shared experiences

and statements. The seventh and final theme had two subthemes: a) Personal Behavior and b) Office Logistics.

In the following section, examples from the data illustrating the major themes and subthemes are provided below. The presentation of data concludes with a brief theoretical analysis, which is reviewed in depth in the discussion section.

The Concept of Passing

Trans individuals do not always feel as though they "pass" in the general public or in the doctor's office. "Passing" signifies a person who can present as being a particular gender without the "original" sex being suspected (Namaste, 2000). The theme The Concept of Passing emerged during conversation when co-researchers answered questions surrounding the concept of passing such as, "Do you feel as though you pass as your preferred gender?" Of the nineteen participants interviewed, six of them voiced concern over the term as a word to describe whether they felt as though others recognized them as their preferred gender. A few participants defined "passing" as the term is currently understood whereas others provided examples of alternatives to the term that was more inclusive. Below, exemplars illustrating this theme are presented below.

Three separate participants expressed their discomfort with the term "passing." For one participant the term has a naturally negative connotation and signifies judgment being placed on trans individuals by cisgender individuals. According to Sophie, a 47-year-old computer programmer in California who has been on HRT for four months and feels as though she passes:

> I don't- (long pause) I have a little trouble with- with the word pass…It's (pause) first of all, it's a little bit judgmental (pause) and for meeee (pause) what's more

> important is that someone perceives me as currently female (pause). And if they see that I started out as male, that- I'm not so concerned about that.

For Sophie, she has trouble with the term because of the ability for someone to cast judgment on a trans individual based on their ability to blend into society as a cisgender male or female. However, she is confident enough in herself and her performance of gender that she does not bother to worry what others see. Specifically, if others notice that she is trans, or started in the male gender, she does not let it effect her confidence in her female gender. Another participant shared similar sentiments over the term "pass."

According to Larry, a 43-year-old student from Texas who has been on HRT for 5 years and has received top surgery and a hysterectomy, "I don't like [the term] passing because if you have pass, you have fail." Larry had direct concern with the term by considering an alternative to the word itself. To pass or fail insinuates a competition of sorts placing certain trans individuals above others based on their ability to successfully "pass." Although this negative connotation daunts the term, there are still those that desire to "pass." According to Meli, a Pacific Islander and Latin web developer in Washington State who has been on HRT for nine months and feels as though she does not pass:

> I'm not a fan of the term, honestly… I mean, I'm conflicted- personally; I'm conflicted because on the one hand I can understand…and my therapist hates the term. And I understand the reasons why…but at the same time there's this-this desire to want to so that, from a safety standpoint.

Meli described herself as being conflicted with the term because she understands the reasons for the term, but she also would like to "pass." For Meli, her desire comes from a place of safety. She does not feel as though she successfully "passes" thus putting her in a greater opportunity for discrimination or harm from others. Other participants defined the

term "passing" as it is understood today. According to Harold, a 33-year-old performer living in New York who has received top surgery and has been on HRT for seven and a half years:

> I do remember that one time that I passed going into the medical experience…I had been having like stomach pains, so I went to a gastroentro-tronologist, entorologist- however you say it. And…it was the first place that I went to where you could put trans [on the medical intake form]. I was shocked…So when I went in [got called back] to speak to like the…initial folks that work on you [nurses who take your vitals]…um, they were like going through all the questions [on the intake form] and then they saw that I put trans [on the intake form] and they like [had no idea]…they fucking flipped their shit…[and said] they never would've known.

Harold described how he "passed" at the doctor's office when the nurses verbally acknowledged that they never would have known he was trans unless he put it on his intake form. This type of experience was shocking for both Harold and the nurses. He was surprised there was even an option on the intake form to mark that he was trans and Harold indicated that the nurses were shocked that someone could so successfully "pass." This experience made Harold feel confident in his ability to blend into the cisgender society. Meli also indicated how good it felt to "pass" in the doctor's office. According to Meli, a Pacific Islander and Latin web developer in Washington State who has been on HRT for nine months:

> When receptionist staff or-or folks in the waiting room…will like…presume or treat me as though that they presume that [female was my] assigned sex at birth…That's when I started to realize that I, in the health context, that I was passing more than I had even realized that I was…It feels good in *any* situation…to feel like you're being perceived as the way that…you're presenting currently.

The concept of passing has a widespread understanding and most trans individuals accept the concept for what it is. Meli is a primary example of this; she understands the concept,

although doesn't accept the term, and still enjoys the feeling of "passing." She relays the affirming feelings when others make assumptions that are ultimately false, but contribute to her identity as female. Although there are conflicts with the current definition of the term "pass," there was one participant in particular that offered a solution to the controversial concept. According to Rachel, a 23-year-old student living in Texas who has been on HRT for 31 months:

> There's a lot of connotations to it and given the fact that, gender isn't- I mean, its something that we perform, but it's also something that is perceived from us…Something that might be a little more (pause) uhh..I can't think of a-a- I can't think of a way to put how it would be…better or an improvement, but…consistently gendered female, orrr..how long have you been regularly gendered, you know gendered, your preferred gender.

Rachel pointed out that gender is performed and others read our gender from our performance. Essentially, we control our gender and the way others attempt to categorize our gender. Some choose to perform a strictly masculine gender, others a strictly feminine gender, while there are some that prefer to blend genders. To combat the negative connotations attached to the word "pass," Rachel proposed the phrase "consistently gendered as your preferred gender." This replacement phrase can serve as a positive alternative for those individuals that do not feel comfortable with the term "pass." Although it is a longer phrase to say, "consistently gendered as your preferred gender" has the high potential to serve as a less judgmental option when discussing the concept of passing, or being consistently gendered as your preferred gender.

Theoretical Analysis. Above, the major theme discussed was The Concept of Passing. Of the nineteen participants, nine mentioned passing while ten did not mention the term "pass." From a co-cultural perspective, the concept of passing is connected to

identity ascription and avowal. Participants expressed a strong desire to avow their own identity. According to muted group theory, it is because of the social hierarchy that is in place in any society, trans participants, as a marginalized co-cultural group, are forced to operate by a communication practice that does not cater to their experiences and preferences (Castle Bell, Hopson, & Ross, 2015; Ramirez-Sanchez, 2008). Although participants have the desire to avow their own identity, the pre-established dominant language does not grant them this ability.

Of the participants that did mention passing, six participants indicated a problem with the term passing. Data explains that the term "pass" has been accepted among many simply because there has been no successful alternative. One participant, Rachel, offers a solution for this conflicting term saying, "consistently gendered as your preferred gender" instead of "passing." Perhaps adopting the terminology "consistently gendered as your preferred gender" can provide a successful option in terminology when referencing the same concept.

Aside from being consistently gendered as their preferred gender, participants talked about their overall healthcare goals when visiting the doctor's office. They also described what has helped or hindered the success of achieving these overall healthcare goals. Below, examples supporting this next theme are provided.

Overall Healthcare Goals

Like most all individuals, trans individuals have particular overall healthcare goals when visiting the doctor. Overall healthcare goals can be defined as the desire to be treated with respect, to be treated for whichever ailment is present, and leave with answered questions when visiting the doctor. The theme Overall Goals emerged during

conversation with interview participants when they were asked, "What are your overall goals when you visit the doctor's office or interact with health professionals?" Of the nineteen total participants, eighteen participants described their overall healthcare goals. Under this major theme, Overall Healthcare Goals, there are two subthemes that speak to participants' overall healthcare goals: a) Helped and b) Hindered. Below, three exemplars summarizing participant's overall healthcare goals are given, each subtheme is defined, and three exemplars are provided for each subtheme.

One participant recognized that his case is atypical and expressed interest in having his doctor's acknowledge his unique situation as part of his overall goals. According to Conner, a white 29-year-old from Texas who has been on HRT for four months:

> Well I want to be treated with respect and I want the doctor to act like they care about what they're doing (pause) I guess in dealing with this situation, I don't want to be just another patient…I want to be given the acknowledgement that I need about what I'm going through because its not a typical situation.

Conner stressed that he should not be treated as "just another patient" because he has more going on than the average patient. He wants the trans aspect of his healthcare to be acknowledged in addition to his common health concerns. Conner would like to be treated from a biopsychosocial standpoint, meaning attention be given to all aspects of his health. Essentially he wants to be treated with respect, which is similar to other participants. According to Rachel, a 23-year-old student living in Texas who has been on HRT for 31 months:

> I'd like for any questions I have to be answered, you know, to the best of someone's knowledge. Id like for my concerns to be heard…I'd like to be treated respectfully, like a fellow human being…Yeah just standard, decent, *reasonable* care. I feel like I deserve, pretty reasonable you know, requests.

Like Conner, Rachel wishes to be treated with respect and more specifically, as a "fellow human being." She emphasized her need to have her questions answered, but also realized that this could only be done to the extent of a doctor's knowledge. As a human being, she feels the right to request her need for a standard level of healthcare from her doctors. For Rachel, reasonable care means fair and equal medical treatment, just like all other patients. Another participant specifically mentioned being treated as a human being. According to Brandon, a 36-year-old graduate student in Texas who has been on HRT for one month:

> Always one of my goals is to…(pause) solve whatever the main problem is that I'm there for…I want to address whatever issue is the issue at hand…and then I also want to build this rapport. So that I know I don't have to change doctors every time…and then…the third is that the overall person is concerned—is a concern of the doctor and is an awareness of the doctor. And so the transgender is sort of that part of the overall person.

Brandon laid out his primary healthcare goals in three layers. First and foremost, his current health problem that initially brought him to the doctor should be addressed. Second, to prevent having to change and update doctors on his specific healthcare situations, Brandon wants to build a level of rapport with his doctors. It can be frustrating having to continually come out to a new doctor at each doctor's visit. By building a level of rapport, Brandon can prevent having to explain his situation each time. Finally, he wants to be treated fully by his doctors, which includes all aspects of his identity and more specifically, his trans identity.

Participant's overall healthcare goals largely encompassed being treated with respect, being treated as a fellow human being while considering all aspects of identity, and receiving the best possible answers to questions. When asked what helped or

hindered their overall healthcare goals, participants mentioned several items. Below, exemplars are provided for each of the subthemes for this theme, Overall Healthcare Goals.

Helped. There were particular things mentioned by participants that helped, or aided, them to achieve their overall healthcare goals. Specifically, the Helped subtheme is defined as distinctive situations or people that facilitated the attainment of a participant's overall healthcare goals.

In most stressful situations, individuals seek some form of a support group to help them through the stressful situation. For one participant, this was key in helping her achieve her overall healthcare goals. According to Meli, a Pacific Islander and Latin web developer in Washington State who has been on HRT for nine months, "Well the things that have helped my goals have certainly been coming out to friends and family…the very biggest thing that's helped- that's helped me was…having a support group of friends." By coming out to her friends and family, Meli discovered she had a support group to guide her through the emotional element of her transition. "Coming out" is a personal process through which individuals choose to disclose their identity to others whereas, "passing" is a public concept where others place a judgment on the trans individual to be of a binary gender, or otherwise. This distinction is important understanding the negative connotations surrounding each of these concepts. Having a support group to comfort you can significantly help in building confidence in the doctor's office. With this confidence, provided by a support group, a trans individual's overall healthcare goals can be obtained. Sometimes a support group can include educated doctors which helps to accomplish overall healthcare goals. This is the case for Harold.

According to Harold, a 33-year-old performer living in New York who has received top surgery and has been on HRT for seven and a half years, "I mean just having doctors that are like well-read, well-informed." Harold feels as though having doctors that are educated on trans issues and medical care help aid him in accomplishing his overall healthcare goals. Doctors who are not informed about trans issues can serve as a barrier to a trans individual's healthcare by not knowing how to care for the individual or by offering incorrect information for their healthcare. Not only having educated doctors on trans issues, but having doctors educated on the specific patient's case is important. According to Conner, a white 29-year-old from Texas who has been on HRT for four months:

> I think realizing that I can't- I have to give all the information I have, like I can't just give part of what's going on with me to the doctor. Like I've had to learn that I have to give every detail of what's going on…because (pause) to me, going through this process is a very sensitive thing. Just…in regards to my health I guess. Just because I'm pushing the border on other health issues that transitioning could cost me to go over.

Conner came to the realization that a doctor must be educated about trans issues *and* his own general health concerns and the only way for that to happen is for him to disclose as much helpful information as possible. In order for a doctor to treat their patient to the best of their ability, the patient must share all useful health information. Conner acknowledged that if he failed to share all the details of his health with his doctor, he could become severely ill considering his other health matters.

Despite there being particular situations or people that helped accomplish participant's overall healthcare goals, there were certainly things that held participant's

back from achieving their healthcare goals. Below, exemplars are provided to illustrate overall healthcare goals being prevented.

Hindered. Participants mentioned specific challenges they faced in trying to accomplish their overall healthcare goals. This subtheme, Hindered, is defined as particular behaviors or feelings that prevented participant's overall healthcare goals from being achieved. Hindered means a difficulty that delays progress, which encompasses both internal and external factors; despite most of the following exemplars being of the internal orientation, any external hindrances should not be disregarded.

For any trans individual, becoming accustomed to the realization that trans is a part of their identity can be difficult considering the amount of pushback a minority group typically experiences within society. According to Kevin, a 34-year-old clinical psychologist in North Carolina who has received top surgery and has been on HRT for three and a half years, "[My trans identity] is definitely something that has gotten in the way." For Kevin, his trans identity has prevented him from accomplishing his overall healthcare goals. Kevin has had experiences where retrieving any level of healthcare was impossible because of the discrimination towards his trans identity. Doctors would not provide him with the necessary level of care based simply on his trans status. More often than not, fear of discrimination is a key component of the hindrance of overall healthcare goals being reached. According to Brandon, a 36-year-old graduate student in Texas who has been on HRT for one month, "I know that- that there have been times that I haven't been able to talk to my doctors as honestly as I should be able to and its been because of fears or because of false expectations that I've had." Brandon expressed he was not able to openly talk with his doctors because of his fears of discrimination or prejudice. Not

being able to honestly talk with his doctors about his healthcare has directly held him back from attaining his overall healthcare goals. An open line of communication with your doctor is important because it provides the doctor with all the information needed to provide the proper treatment. In some instances, patients do not even give themselves the opportunity to talk with their doctors; such is the case with Jared. According to Jared, a 36-year-old graduate student living in Texas who has been on HRT for one month:

> Yeah, definitely the-the avoiding of healthcare that I- that I did for a long time… I didn't wanna be treated in a way that felt- that made me feel less human. (pause) and I- I guess, I didn't know who I could go to see that was going to treat me in a way that felt really dignified so I just avoided it altogether.

Jared avoided entering a health situation altogether because he feared discrimination, or being treated as "less human." He also had no direction as to where he could go to get medical treatment that did not also include a level of discrimination. Sometimes the fear of this type of treatment can overcome someone to the point that they avoid healthcare completely, thus preventing the accomplishment of their overall healthcare goals.

The accomplishment of a trans patient's overall healthcare goals involves many factors. Generally, trans patients want to be treated with respect and like a fellow human. Having a support system and an educated doctor can help this, but it can also be hindered by the fear of discrimination or avoidance of healthcare altogether.

Theoretical Analysis. Previously, the major theme Overall Healthcare Goals and the subthemes, Helped and Hindered, were discussed. From a co-cultural perspective, the varying outcome behaviors (assimilation, separation, and accommodation) and communication approaches (assertive, nonassertive, and aggressive) can help participants achieve their overall healthcare goals. Participants have the opportunity to select any

approach and pair it with any outcome, ultimately providing nine different ways to accomplish their overall healthcare goals. Some participants chose to enact a nonassertive assimilation pattern, meaning they were timid with their doctor, adapting to or settling for their doctor's concerns and wants for the participant's healthcare. However, other participants portrayed an aggressive separation pattern pushing their needs on the doctor while rejecting the concerns of their doctor. Furthermore, there are myriad communication strategies that can aid participants in how they handle their visits with doctors. Dependent upon the doctor's behavior and the personality orientation of the participant, co-cultural theory provides many different approaches to achieve participants overall healthcare goals.

Another major factor that contributes to the type of healthcare trans individuals receive is location. Below, this theme is defined and illustrated through exemplars.

Location Matters

It is important to consider location as a primary aspect of the type of healthcare a trans individual receives. The theme, Location Matters, emerged organically when talking about experiences with doctors. Of the nineteen total participants, thirteen participants described location as a contributing element of the type of healthcare they received. Under this major theme, Location Matters, there are two subthemes that speak to the type of healthcare participants experienced based on their location in the United States: a) Advantage and b) Disadvantage. Below, each of the subthemes is defined and three exemplars illustrating this theme are presented below.

Advantage. Several participants mentioned location as an advantage to receiving proper healthcare. This subtheme, Advantage, is defined as participants experiencing

positive healthcare situations and receiving more access to healthcare opportunities in regards to their location within the United States.

As trans education, especially for medical professionals, begins to spread, there are specific locations, or regions, that are far more advanced than others. According to Larry, a 43-year-old student from Texas who has been on HRT for 5 years and has received top surgery and a hysterectomy, "I do realize that I have to tell you that I do come from a lot of places of privilege here in Houston, because there's been so many activists before me…that make things like that a little bit easier for me." For Larry, he clearly realizes that his position in Houston makes his transition and access to positive healthcare easier. Having activists advocate for the improvement of trans healthcare can significantly improve the education of trans medical issues in the healthcare environment. Just like with any issue within a minority group, there is a history of people that have contributed to building the improvements. Jared, like Larry, recognizes his advantages in the area he resides in. According to Jared, a 36-year-old graduate student living in Texas who has been on HRT for one month:

> I think that a lot- a lot of healthcare professionals, at least in the area of the country that I live in, which is a very small bubble, are really open and excited to learn about trans issues and become more trans competent…I don't think that was necessarily the case when I was in Texas, but…in liberal Portland, it definitely is.

Jared has noticed the growing opportunities available to him in regards to healthcare. Generally, when someone is excited about a topic, they are more eager to discuss and learn about that topic. This is the case for Jared's experience with healthcare professionals in his area; they are willing and eager to educate themselves on trans issues.

However, Jared makes it clear that this is only the case for his experiences in a small area of the country.

In some instances, all it takes is one healthcare professional to completely shift the healthcare access in a central location. According to Linda, a retired police officer in her 50s who has been on HRT for three years and has scheduled her bottom surgery, "She- it's amazing, you know that, she-she, she's been great, really great. And [Washington state] needed her so bad. I mean it is amazing. Cause there was nobody here. I think there are two endocrinologists in the entire county." Linda talks about how the arrival of one doctor improved the overall healthcare access in her area. By adding a new doctor to the list of healthcare professionals that can and will treat trans individuals, the trans community in that area can be better served. Receiving an upgrade in healthcare in one area can improve the attitudes and healthcare for many trans individuals.

As healthcare continues to improve in particular areas, many trans individuals reap the benefits of these improvements. Unfortunately, there are still many areas within the United States that are lacking this type of improved healthcare with excited, open, and educated healthcare professionals. These underprivileged areas are attributed to either the general urban, or rural, geographical location, or the lack of a queer population. It is also possible that both of these issues are present in a single region. Below, exemplars are provided to illustrate how location can serve as a disadvantage to proper healthcare.

Disadvantage. Many participants recognized how their location served as a disadvantage to receiving positive healthcare. This subtheme, Disadvantage, is defined as participants noticing the downfalls of the location or region they resided in related to the opportunities available in proper healthcare.

There are a multitude of locations in the United States that have a lack of education or willingness to learn about trans medical issues. According to Brenda, a 70-year-old retired press operator in Washington State who has been on HRT for three years, "There is virtually no real support for transgendered people in this area. And especially in the medical sense of it." Brenda reported feeling unsupported in her area of Washington State. She spoke of how there is no support within the community, not just within the health context. With no support, especially medical support, the likelihood of proper healthcare is grim. According to Conner, a white 29-year-old from Texas who has been on HRT for four months, "I moved up here in 2010 and I haven't had a set physician because the majority of physicians in this town are incompetent." For Conner, his perception is that his location has no competent doctors. It is possible there are doctors who are educated in trans issues in his area, just not accurately, meaning they have incorrect information to provide for trans individuals. This has prevented Conner from accessing a regular physician for his healthcare, including the trans aspects of his identity.

There are even locations where a physician is not accessible at all. According to Rachel, a 23-year-old student living in Texas who has been on HRT for 31 months:

> Especially kind of in this area, there's a- you have- you have this expectation when you go into a lot of kind of like, professional contexts…that you're being ignored, talked over, that your concerns are going to be disregarded. Or that you're just going to get made fun of or harassed.

Rachel has come to expect a certain level of care in her area that is unacceptable. Not only in the health context, but also in all professional contexts, a level of disrespect is expected. As a trans individual, the everyday struggle of being acknowledged can be

difficult, but when it crosses over into the professional contexts, it can be discouraging. It seems useless to approach a healthcare professional if they are perceived as going to react in ways that are dehumanizing and offensive.

Theoretical Analysis. Discussed above was the major theme Location Matters including two subthemes, Advantage and Disadvantage. According to co-cultural theory, there are situational factors that impact co-cultural group members' communication in a dominant context. Of these factors, geographical location is most prominent in talking about the major theme Location Matters. Geographical location can directly influence how a participant achieves good healthcare (Buzzanell, 1999). As demonstrated in the subthemes, an individual's location can serve as a major factor to the determination of good healthcare.

Location functions continually to empower or disempower co-cultural members. If a participant enters a trans-friendly space they are empowered by the location and the likelihood of positive healthcare is significant because the space is transformed into a safer environment. When discussing standpoint theory, it emphasizes the ways in which an individual's position within culture structures their life (Parker, 2002). Paired with geographical location, a trans individual's location within culture helps them prepare to enter the healthcare space, expecting either a negative or positive experience.

Whether the location of a trans individual serves as an advantage or a disadvantage for the trans person, there are certain strategies used by participants when communicating with their healthcare providers. Some of these strategies are used in a positive manner and others are used as somewhat of a defense mechanism. Below, each

of the strategies is defined and exemplars are provided for each to illustrate their use in a healthcare situation.

Co-Cultural Strategies

Whether knowingly or not, most people use particular communication strategies when speaking to people in a higher power position, meaning a dominant culture. For instance, many participants used certain strategies when speaking with their doctors. The theme, Co-Cultural Strategies, is defined as the use of different approaches to potentially stressful conversations by non-dominant cultures when communicating with dominant cultures. Co-Cultural Strategies emerged organically when talking about experiences with doctors. Of the 37 strategies extended from the co-cultural theory (see Castle Bell et al., 2015), participants exemplified 33 different strategies. However, eleven or more participants used five noteworthy strategies, which are discussed in this theme. These strategies include: a) Emphasizing Commonalities, b) Communicating Self, c) Rationalization, d) Maintaining Barriers, and e) Educating Others. Below, each of these strategies is defined and three exemplars are provided to help illustrate the participants' use of the strategy.

Emphasizing Commonalities. Twelve of the nineteen participants spoke of emphasizing the commonalities between them and their doctor. Orbe (1998b) defines this strategy as "emphasizing commonalities" explaining it as "focusing on human similarities while downplaying or ignoring co-cultural differences" (p. 8). Here this theme, Emphasizing Commonalities, occurs as participants express feeling more comfortable with doctors who had similar qualities and in some cases participants had a doctor that

was also trans, making communication about their healthcare easier. Below, three exemplars are given to summarize how participants used this strategy.

There are trans individuals present in nearly any kind of profession and for some, this profession is medical care. Although far and few, some trans individuals have the opportunity to gain access to a trans-identified doctor. According to Meli, a Pacific Islander and Latin web developer in Washington State who has been on HRT for nine months:

> I was searching for gender therapist. This was one therapist who identified as being transgender…. I thought you know, who else better to understand my situation than…somebody who was also transgender… I think that knowing that this doctor, the doctor that deals with somebody that specializes with those that are transgender makes it so much easier for someone that is to have easy communication-have easy communication with them.

During Meli's search for a gender therapist she happened to find one that identified as trans which, for her, made communicating about her healthcare much easier. Sharing the identity as trans is possibly the best situation to have with a doctor because the level of understanding reached is heightened. For others, simply having a provider who treats others as a fellow human can be helpful to establish a better standard of communication. According to Jared, a 36-year-old graduate student living in Texas who has been on HRT for one month:

> I think that experience that I had with the first doctor that I saw when I came to Portland, Dr. Barnes- she was so amazing and supportive and just…kind. In a way that made me…feel like she saw me and saw all of me as a human. And I guess that restored some sort of like, faith in other providers.

Jared appreciated how supportive and kind his doctor was, noting how his doctor acknowledged him as no one other than Jared. Despite having a complex body to treat, being granted the recognition of gender identity is important to the mental and emotional

health for a trans individual. Experiencing a doctor who treated him with the respect any human deserves helped to restore his faith in providers, that there could be others similar to this doctor he encountered. Some participants felt drawn to doctors other than their primary care physician. According to Linda, a retired police officer in her 50s who has been on HRT for three years and has scheduled her bottom surgery:

> The very first person I told was my neurologist. I had-have, still have, I have a really good rapport with him…He's my age, maybe just a little bit older…just as mellow as nicest guy. I've seen him downtown at different functions that we've gone to, different auctions, you know. And he's just the nicest guy and I thought, you know, you oughta tell him. He's not my primary doctor, but I want to tell him. I see him more than my primary doctor.

For Linda, she placed emphasis on the commonalities between her and her neurologist. These commonalities included close in age, mellow and nice attitude, and similar interests in leisure activities. Linda felt compelled to disclose her trans status to her neurologist based on the commonalities they shared.

Having shared traits and interests certainly helped participants in talking with their doctors, however for some, it was more about how they viewed themselves. Several participants felt comfortable enough to share with their doctors without searching for or noticing commonalities. Emphasizing the commonalities of their doctors helped participants increase the positive experience of healthcare. Participants, in direct relation to co-cultural theory, utilized the strategy, emphasizing commonalities. By focusing on the human similarities, participants were able to temporarily ignore their trans status as an adverse component to their doctors treating them in a constructive manner. Below, the theme, Communicating Self, is defined and exemplars are provided to illustrate the use of the strategy.

Communicating Self. Twelve of the nineteen participants discussed ways in which they talked about themselves and their healthcare with their doctors. Orbe (1998b) defines the strategy "communicating self" explaining it as "interacting with dominant group members in an authentic, open [manner], and used by those with strong self-concepts" (p. 9). Here this theme, Communicating Self, occurs as participants report feeling comfortable and confident to discuss their trans identity with their doctor without fear of discrimination or rejection. Below, three exemplars are given to show the ways participants communicated their self.

For many trans individuals, building confidence can be a difficult accomplishment because of their status as a minority group and thus, the common discrimination and rejection from society. However, twelve participants talked about their ability to demonstrate their confidence and stability in themselves, which improved their communication with others. According to Carl, a 55-year-old living between Texas and Massachusetts who has been on HRT for 11 months:

> Well…this thing that has helped me most in just everything, whether it's in a medical office or anywhere else is…being myself. I am so centered, I have- I have a center and I have stability that I have never had in my life before… I *know* who I am. I don't have to look outside to find it.

In order to ease the communication with others, including medical professionals, Carl realized he had to find himself first. Once he discovered and accepted that he was trans, he was able to create the level of stability in his life needed to sustain a healthy communication pattern with others. Harold shares a similar experience with finding his confidence when entering a healthcare setting. According to Harold, a 33-year-old performer living in New York who has received top surgery and has been on HRT for

seven and a half years, "I can speak about my body and its parts without feeling triggered. And so, I think that like, my patient care changes as I come-I come in confident, and ready- and ready to speak about my problems in a space where- that I don't feel as vulnerable." Harold has noticed his level of healthcare changing as his confidence increases. He is able to discuss his body comfortably and its trans-ness without feeling the need to be defensive. Harold can discuss the sensitive issues surrounding his trans body without the threat of being judged or rejected. Harold's ability to prove his confidence in the doctor's office demonstrates the improvements healthcare communication can have through open and honest communication.

In addition to Harold, Brandon also shared the sentiments of needing improved healthcare communication. According to Brandon, a 36-year-old graduate student in Texas who has been on HRT for one month:

> The communication is a big thing. The more I've been able to communicate openly and honestly the better we…been able to…accomplish those goals, me and my medical team and (pause) I know that- that there have been times that I haven't been able to talk to my doctors as honestly as I should be able to and its been because of fears or because of false expectations that I've had and now that I've- I've been talking to them and letting them know what's going on and…you know, that I'm- that I'm going through transition, that's opened up and-and solved a lot of that problem.

Once Brandon opened up and began to speak honestly about his health, he realized he and his medical team could accomplish their goals at a faster rate. He was able to voice his concerns over time, thus improving the healthcare interaction. Overcoming his fears and false expectations seemed to be his main struggle in communicating about his trans status to his doctors.

For some participants, it became easy to communicate with their doctors about their health and their trans status. However, for others, even the attempt to do so was met with disinterest. Communicating Self served as a helpful tool for many participants. The ability to interact with their doctors in an authentic and open manner aided participants in establishing a positive healthcare experience. Conversely, some participants were met with a dissatisfactory experience, despite having a strong self-concept when interacting with their doctors. Several participants attempted to explain why they believed their doctors reacted in a negative manner. Below, the theme, Rationalization, is defined and exemplars are provided to illustrate the use of this strategy.

Rationalization. This strategy was the most common used by participants with fifteen of the nineteen interviewees demonstrating their use of the strategy. Rationalization, recently added to the co-cultural theoretical framework, is defined as "providing an alternative explanation or justification that downplays or diminishes the serious nature of various forms of verbal or nonverbal communicative injustices committed by dominant group members" (Castle Bell et al., 2015, p. 1). Here this theme, Rationalization, is defined as participants speculating as to why their doctor was perceived to be uneducated on trans issues, treated them badly, or did not feel comfortable treating trans individuals. Below, three exemplars are provided to clarify how this strategy was used.

It tends to be easy for most individuals to give reason, or even excuses, for another's actions to grant the benefit of the doubt. The participants that demonstrated this strategy seemed to like to think that their doctors acted in the way they did for any reason

other than their trans identity. According to Conner, a white 29-year-old from Texas who has been on HRT for four months:

> I did go to that- a different doctor recently for my back and I don't know if he just wasn't having a good day, but or he realized I was trans. But he was kind of short with me. So I don't really know what the situation was. If it was just- it was the end of the day and he wanted out of there or he realized I was trans and didn't really want to deal with me.

Conner recognized there was a possibility that his doctor treated him in what he perceived to be an unpleasant fashion due to his trans status, however, he tried to rationalize his doctor's actions by hypothesizing his doctor was having a bad day. He attempted to use the excuse of having a bad day as a way to pardon his doctor's actions on that day, although he recognized the possibility that his doctor's behavior was due to his trans status. Conner blamed his doctor's behavior on external factors.

Other participants acknowledged the difficulty in medically treating a trans patient. According to Meli, a Pacific Islander and Latin web developer in Washington State who has been on HRT for nine months, "I think its gotta be a great, huge challenge for anyone in the medical community to…work with us. Be empathetic, but at the same time have boundaries." Meli sees her doctor's actions as a product of the complex healthcare treatment a trans individual requires. In a sense, Meli is blaming her trans identity for the way some doctors react and treat their trans patients, deeming it a massive test for doctors to separate the professional from the unprofessional.

There were a few participants who struggled to rationalize doctors' ignorance, or perceived lack of knowledge or want for knowledge. According to Rachel, a 23-year-old student living in Texas who has been on HRT for 31 months:

> It's possible for people to be like *okay* with transgender folk, but kind of oblivious or just, you know ignorant. And there's not necessarily anything wrong with ignorance itself, but its- I feel that the medical domain is kind of a context in which, we should be reasonably understood, you know.

Ignorance, Rachel explains, can be acceptable for some individuals, but not necessarily in the medical field. It is generally an accepted expectation that when going in for an appointment, the doctor will have the needed understanding to provide the necessary healthcare treatment. However, in most participants' experiences, this is not the case.

Most of the participants tried to justify their doctor's perceived lack of appropriate behavior or treatment. Although, a significant number of participants also gave instances where they felt the need to defend themselves against the negative behaviors of their doctor. Rationalizing their doctors behavior helped participants make sense of the ways they were treated. Offering an alternative explanation or justification of their doctor's behavior allowed participants to believe their doctor's behavior was not as critical as it really might have been. The perceived communicative injustices committed by dominant group members can be detrimental to a trans individual's healthcare, but with the use of rationalization, participants were able to reject the harmful influences. Below, the theme, Maintaining Barriers, is defined and examples are given to show how participants used this strategy.

Maintaining Barriers. Of the nineteen interviewees, eleven used the strategy of maintaining barriers. Orbe (1998b) defines the strategy "maintaining barriers" explaining it as "imposing, through the use of verbal and nonverbal cues, a psychological distance from dominant group members" (p. 9). Here this theme, Maintaining Barriers, is defined as participants feeling the need to back away from a situation and build a psychological

blockade, verbally or nonverbally, to all communication with their doctor. Below, three exemplars are used to demonstrate participants' use of this strategy.

When in an uncomfortable situation, most people typically have a fight or flight response; they either stay and face the situation or flee from the setting altogether. For the participants, their perception was that their doctor avoided them, changed their attitude half way through the visit, or had an unsatisfactory behavior from start to finish. According to Larry, a 43-year-old student from Texas who has been on HRT for 5 years and has received top surgery and a hysterectomy, "I was just miserable. I was super uncomfortable and so I just was like, you know what, if they're not gonna treat me right and I'm not dying, I'm going home. (laughs) so I did." Larry describes an experience that was less than satisfactory and left him feeling as though he needed to back away from the situation. Rather than waiting for the medical staff to treat him, after he had waited for quite some time, he decided he was going to leave; Larry was not willing to sit around feeling the way he did. Larry maintained his barrier nonverbally by leaving the situation without having to vocalize his feelings or frustration, but not all trans persons respond to similar circumstances in the same fashion. According to Garrett, a 33-year-old occupational therapist in Texas who has received top surgery and a hysterectomy and has been on HRT for over 10 years:

> So that doctor was real cool and then (pause) prescribed my testosterone and *then* said that, after that, he said, "Well I'm not going to accept insurance anymore because insurance doesn't cover transition." Which at that time, it did not. Well, it still doesn't its just, you gotta be kinda weird on how you code stuff. Anyway, so, and I said, "Well, you know, I don't really need to come back here much except for blood work." And he's just "No, no" blah blah blah. And so he became a total dick about it and so I was like, "Fuck off!"

Garrett described a confrontational experience with his doctor that left him irritated. His doctor chose to stop treatment in care during one particular visit and for reasons, Garrett felt, had no substantial support. This experience left Garrett angry and with the need to verbally speak out, thus building a psychological barrier with his doctor.

Harold shares a similar encounter with one of his doctors. According to Harold, a 33-year-old performer living in New York who has received top surgery and has been on HRT for seven and a half years:

> I like left in a *huff* and all these people were like thinking the doctor was being murdered or whatever, you know. And then…I left and I came *charging* back in and I opened the door to his office and he was like (gasp). And I was like, "You're gonna charge me $40 for this too!?" And he's like, "No, this one's free." And I was like pfft (all laughs). And then I just left, like snot-nosed- cause I was so psyched, cause that was gonna be the appointment I got testosterone and instead I had this like, really fucked up experience.

For Harold, the excitement of his first appointment to start his hormone replacement therapy ended in devastating tears. The instance left him so distraught, he felt the need to verbally talk to the doctor in order to show the barrier being built between him and his doctor. At the time of the interview it was easy for Harold to laugh at the "fucked up experience" he had, but it was hard for him to hide just how much it had impacted him in the moment.

Leaving a doctor's visit disappointed is something with which many trans individuals are familiar. Part of this disappoint comes with having a doctor that does not know enough information to treat the health concerns that come with being trans, or to even understand what it means to be transgender. Maintaining Barriers served as a tool for participants to separate themselves from the toxic healthcare situation. Participants, both verbally and nonverbally, detached from their doctors and their doctor's

communicative practices. Some participants were certainly more aggressive in fostering a separation while others were nonassertive simply by leaving the situation. Below, the theme, Educating Others, is defined and exemplars are provided to illustrate the ways in which participants had to educate their doctors.

Educating Others. Fourteen of the nineteen participants spoke about their having to educate their doctors. Orbe (1998b) defines the strategy "educating others" as "taking the role of teacher in co-cultural interactions; enlightening dominant group members of co-cultural norms, values, etc." (p. 9). Here this theme, Educating Others, is defined as participants feeling the need to teach, or inform, their doctors on trans-related information, medically, socially, or in the general sense of what it means to be transgender. Below, three exemplars are given to exhibit the ways participants used this strategy.

In the best of situations, when someone is unaware of, or uneducated about, trans issues they ask questions with genuine interest and curiosity. Typically a person can detect if questions come from a place of malevolence by the type of questions asked and the tone in which they are asked. In a scenario of genuine interest, many trans individuals do not mind sharing information or educating people in their lives, including their doctors. According to Larry, a 43-year-old student from Texas who has been on HRT for 5 years and has received top surgery and a hysterectomy:

> She's running each of the questions off and she goes, "When was your last period?" And then stopped and looked at me and said, "Wait, why does it say this?" And I said, "Because I'm a transgender male." And she said, "Wait, I'm sorry. I don't understand." And so I had to explain it to her and she's just like, "Oh!" (pause) because like, my last period had been like, you know a year or something (laughs) and she was like-I'm like "I'm on testosterone, it stops, you know blah blah blah." Gave her the whole rundown.

Larry identifies himself as an educator of trans issues and this experience justifies this self-given title. A nurse was going through the intake form, asking all the questions listed, but when she reached one that did not seem to fit with the others, she got confused. This particular nurse asked from a place of sincere misunderstanding and Larry showed no conflict in explaining his trans status to her.

For other participants, it became frustrating to be educating their medical professionals consistently. According to Ariel, a 24-year-old from Texas who has received hair removal treatment and bottom surgery and has been on HRT for 18 months, "Generally everyone (pause) doesn't treat me poorly. It's just annoying that I usually know more than them. I have to educate them." Ariel clearly recognizes she knows more about her trans status than her doctors and not even from just a personal level, but from a medical standpoint as well. She is able to separate doctors treating her badly and doctors just not knowing how to treat her because she is trans.

There are some incidents where a doctor's lack of trans education can cause trans individuals to worry about their safety, like with Kevin. Kevin, a 34-year-old clinical psychologist in North Carolina who has received top surgery and has been on HRT for three and a half years, reports "So I feel like I need to teach other people and there are very few people around here that have any clue about…transgender issues. And it feels very unsafe." As he describes, Kevin feels a social obligation to educate others about trans issues because of the level of safety around him. Unfortunately, uneducated can translate into unsafe in any location. In some instances, unsafe can mean blatant violence based on prejudice and discrimination towards the trans community.

Theoretical Analysis. Above, five major themes were discussed: 1) Emphasizing Commonalities, 2) Communicating Self, 3) Rationalization, 4) Maintaining Barriers, and 5) Educating Others. These documented instances of using each of the five strategies above strengthen the legitimacy of co-cultural theory. To date, co-cultural theory's communication strategies have not been applied to the trans community. As demonstrated by the exemplars for each strategy, co-cultural theory is beneficial in explaining the experiences of trans individuals, as co-cultural members, in the healthcare context. Although only five strategies were discussed, participants exhibited the use of 33 of the 37 communication strategies, including the five discussed here, when interacting with healthcare professionals. The four communication strategies participants did not use include Exemplifying Strengths, Sabotaging Others, Journaling, and Reporting to Authorities (see page 48 for a full list of the communication strategies).

Data indicates that seeing doctors who lack significant trans medical information can results in a hostile or unpleasant environment for the trans patient. Sometimes medical professionals know about trans issues, or that trans individuals exist, but they either choose to disassociate themselves from this cultural group or specialize in different types of medical care. Another possibility is that doctors have not come in contact with a trans individual and therefore, have had no reason to become knowledgeable about trans medical needs. For whatever reason they lack knowledge, trans participants expressed frustration when they saw doctors who did not have the necessary medical education to treat trans community members. Below, the theme, Incompetent Doctors, is defined and exemplars are presented to illustrate the ways in which the participants encountered incompetent doctors.

Incompetent Doctors

Trans patients do not always leave a healthcare visit feeling like they received the correct, or sufficient, medical treatment from their medical professionals. Incompetent Doctors is defined as participants noticing their doctor's inability to learn when it comes to the general knowledge of trans issues and how to medically care for trans individuals, ultimately deeming the doctors as useless. This theme emerged organically when talking about experiences with doctors. Of the nineteen total participants, eighteen participants described having some capacity of an incompetent doctor. Below, several exemplars illustrating participant's experiences with incompetent doctors are presented.

The need to educate a doctor on trans issues can leave a trans individual wondering why they even bother going to the doctor if the doctor is unable to treat them. According to Harold, a 33-year-old performer living in New York who has received top surgery and has been on HRT for seven and a half years, "Having to educate my doctors…has always been like so frustrating and like- also it gives- it leaves me like suspicious and with like, a lack of confidence in their abilities." Based on Harold's history of having to educate his doctors, he has started to doubt the competence of his doctors on trans issues. In general, anyone would like to go to the doctor knowing the doctor will be able to answer any question and treat any ailment or medical issue. Unfortunately, this is not the case for many trans individuals. According to Brenda, a 70-year-old retired press operator in Washington State who has been on HRT for three years:

> Especially the doctors in the VA. When I was checking them out. They have a policy that they will…treat transgender—trans. But, they don't have any. The doctors aren't educated about transgender. Not in this hospital at least. So in seeing, I saw two doctors there trying to- I would like to have gotten my entire treatment program at the VA because the resources available to them.

> But…(pause) they just- they didn't know anything about trans so they were asking me! The patient.

With Brenda's experience, the doctors at the Veteran's Affairs (VA) have a policy that they are willing and able to treat trans individuals. When she visited the facility there, however, she found the opposite. Being a veteran, Brenda should have been able to receive her medical treatment, both in general and related to her trans status, all at the VA, but this was not an option because of the doctors' incompetence.

As shown by Brenda's description, sometimes the doctors depend upon the patient to know what is best for treating themselves. According to Harold, a 33-year-old performer living in New York who has received top surgery and has been on HRT for seven and a half years:

> I even came to him once and I said, "Look, I've got a friend who's doctor put him on some medication to give him his- to give him another period. Like, he's been on testosterone for a year so now he is gonna get another period to kind of, clean out his junk..like clear out whatever was left in the uterine lining." And I said, "Well I wanna know should I do that? Like, is that a smart move?" And he was just like, "Okay! Yes!" And he's just like, prescription pad in hand like, "Hey, here you go!"

Harold's doctor in this occurrence never gave him an answer, or at least an educated answer. Harold proposed an option that he had heard of and wanted to know the validity of the treatment, but his doctor proved to have no knowledge of the treatment or whether it was a good decision. Rather, his doctor assumed it a standard form of care and gave Harold a prescription to fulfill what his doctor thought were his wishes. A doctor's level of perceived incompetence can go so far that they do not wish to learn anything about trans issues. According to Brandon, a 36-year-old graduate student in Texas who has been on HRT for one month:

> I didn't wanna be with somebody who didn't understand or didn't seem to have the care and capacity for dealing with a transgender person. And I mean, he- he told me in his own words that he didn't know anything about this and didn't want to learn. And so I didn't- I didn't wanna be with that anymore.

For Brandon, he quickly realized the inability to communicate with his doctor about trans issues because of his doctor's unwillingness to learn. Even though Brandon was happy to educate his doctor, his doctor rejected the education, thus giving Brandon a reason to find a better doctor. Rejection, in any situation, is not comforting and can affect a trans individual's mental, physical, and emotional health.

Regardless of the root of the belief, some doctors can have preconceived notions of what trans is or means. According to Kevin, a 34-year-old clinical psychologist in North Carolina who has received top surgery and has been on HRT for three and a half years:

> Just before I was involved with my current gynecologist who does my hormones and…I had to tell her about my sexual history and my self-identity and (pause). She just didn't get it! I mean, she did not get it at *all*, I mean she- you know, she was like, "So wait a minute, you're a lesbian?" and I'm like, "No, no, no, no. I'm- I'm a fe- I'm a transgender person who is attracted to women." And she was like, "So you're a lesbian?" And I'm like, "No! aha. I am born- I was born female. I am transitioning to be the male that I am- that I am. And I am attracted to women." And so I had to educate her in- in that way.

Kevin made a desperate attempt to educate his doctor on what it means to be trans, but she was disinclined to accept trans as a valid identity. His doctor had the idea that biological sex and sexual orientation were one in the same, making him a lesbian because he is attracted to women and was born female. Although Kevin's doctor knew about trans, the information she had was completely inaccurate.

A base layer of education in medical professionals could be a useful tool for both the professionals and trans individuals themselves. According to Karen, a Hispanic and

White 27-year-old from Texas who has been on HRT for nine months, "But…I had my visits with doctors where they treated me like shit, had very little education…But like I said, I don't know- I don't feel like the doctors in general have- have a good you know (pause) education about trans issues." Karen talks about her doctor's visits that ended badly based on the fact that the doctor's had no education on trans issues. It is when an uninformed doctor turns into a bad experience that the doctor receives the title of incompetent doctor. It is possible for a doctor to be uneducated and still treat a trans individual with the same amount of respect as any other patient. Giving a patient respect and the simple feeling of dignity can help the healthcare interaction improve. Whether or not a doctor has specific knowledge surrounding trans healthcare should not affect how they treat their patients.

Theoretical Analysis. The major theme, Incompetent Doctors, was discussed above. An incompetent doctor can make for a frustrating and disappointing healthcare experience. It is worth noting that not all doctors are incompetent to overall medical treatment, just specifically to trans medical care. Many trans patients base their ideas and opinions of doctors on their experiences, whether good or bad. From a co-cultural perspective, the use of societal power by doctors is evident in their incompetence. Despite the lack of knowledge or care about trans individuals, participant's doctors still enacted a level of power, as dominant group members, over their patients.

Demonstrating this level of social power reinforces the social hierarchy over trans individuals, stigmatizing them as non-dominant group members with no voice in their healthcare and unable to resist the social hierarchy altogether (Castle Bell, Hopson, & Ross, 2015). Further, participants are reminded of their lack of privilege as doctors reveal

their lack of competence surrounding their patient's healthcare or culture. A doctor's display of incompetence demonstrates a reinforcement of the social hierarchy; a dominant group member can be incompetent and still enact their level of power over non-dominant group members. Doctors presume their power status, establishing a set of norms that accommodate their own communication preferences, placing participants in the social location of an outsider (Matsunaga & Torigoe, 2008).

Below, the theme, "Good Doctors are Good and Bad Doctors Suck," is defined and exemplars are provided to illuminate the kinds of experiences the participants have had with their doctors.

"Good Doctors are Good and Bad Doctors Suck"

Bad Experiences. Trans patients do not always report feeling like they had positive interactions with their doctors. Bad experiences are defined as those experiences that involve a doctor who leaves a trans patient feeling distressed, uncared for, and as though they are not authentic. The theme, Bad Experiences, emerged during conversation with interview participants as they responded to the following questions, "Can you share an experience in a health environment that left you feeling like it was harassment or discrimination, if you've had one at all?" and "Do you feel comfortable in the health context, why or why not?" Of the nineteen total participants, eighteen participants described at least one bad experience with their health professionals. Under this major theme, Bad Experiences, there are four subthemes that speak to the participants' bad experiences: a) Uncomfortable, b) Doubting Sanity, c) Invasive, and d) Ignorant. Each of the subthemes is defined and exemplars illustrating this theme are presented below.

Uncomfortable. One particular type of bad experience participants had with their doctors occurred when there was a level of awkwardness or discomfort present in the encounter. Specifically, the Uncomfortable subtheme is defined as participants having experiences with a doctor where either they or the doctor were uncomfortable, ultimately leading to no healthcare treatment.

For some participants, their doctor made it clear that they were uncomfortable with their trans status. According to Brenda, a 70-year-old retired press operator in Washington State who has been on HRT for three years, "My doctor was uncomfortable treating me as a transgendered person…he wouldn't keep me on as his patient…So anyway, I had to go over to the west side of the state, over to Seattle, in order to finally find a doctor that would work with me." Brenda's doctor was transparent with his feelings about treating a trans person. She was forced to seek healthcare in another area of the state because her doctor refused to provide her with the necessary healthcare.

Not all doctors are as forward as Brenda's about their discomfort in treating a trans individual. Sometimes the trans patient experiences naturally lead them to expect a certain level of discomfort going to the doctor. According to Rachel, a 23-year-old student living in Texas who has been on HRT for 31 months:

> I'm reasonably familiar with healthcare providers and so forth, lets just say I've been in hospitals and clinics and so forth, a lot. So, I don't generally have much anxiety about medical treatment as it stands by itself…It's more (pause) the- the discomfort that I would have going in is typically related to either not being sure if they're going to treat me okay or knowing that they probably aren't.

Rachel discusses how she is familiar with seeking healthcare and therefore, her anxiety comes from not the medical care itself, but the doctors. Knowing there is a possibility

that the doctors might not treat her with respect, or that they for sure will not treat her, keeps Rachel from encountering positive experiences in the health context.

Some doctors can leave the trans patient feeling out of place and like a thing versus a person. According to Kevin, a 34-year-old clinical psychologist in North Carolina who has received top surgery and has been on HRT for three and a half years, "To where its like I'm obviously this like, Jerry Springer sort of…token and its-its- he's cool and shit, but I mean, it makes me feel like- like a freak show, like a circus freak show oddity. And…so I'm afraid to go to doctors." For Kevin, he has a doctor that he describes as cool, but one particular experience left him feeling like he belonged in a "circus freak show." This kind of uncomfortable incident made Kevin fearful of the same kind of treatment with future doctors, thus leading him to avoid healthcare altogether.

Like Kevin, because of how their doctors treated them or the things their doctor said, there are other participants that felt as though they had little sanity. The amount of influence a doctor has on a trans patient's mental, physical, and emotional health is substantial.

Below, the subtheme, Doubting Sanity, is defined and exemplars are given to show how participants felt their doctors made them feel less sane.

Doubting Sanity. Another type of bad experience many participants expressed was when their doctors doubted their sanity. In detail, the subtheme Doubting Sanity is defined as participants encountering doctors who questioned their rationality or did not believe their self-proclamation of being trans was correct.

It is understandable that a doctor would want to make sure a patient knows the permanence of their decisions, but sometimes this reassurance can come off as

patronizing. According to Jaston, a Palestinian American 25-year-old living in Texas who has been on HRT for 20 months:

> I've not…been a- a stranger to these questions, but. Like, asking like, "Are you sure?" "You know its permanent?" You know, all of those things and then I guess I had to gently remind her that, "Yeah! I know!" This isn't something I take lightly, I'm not…you know, contrary to popular belief, I'm not a lesbian who cant- cant take it as a girl, you know…Like, you don't say these things to a trans person, because obviously they've done a lot of research, for the most part, you know.

As Jaston describes, he is used to getting the routine questions from doctors, assuring them he realizes the decisions he is making. However, in this instance, he had to debunk a common myth for his doctor and ensure he knew he was indeed a trans individual. It can seem trivial to trans individuals to have to explain their trans-status to their doctor from a basic level of understanding. Like Jaston says, many trans individuals conduct a significant amount of research prior to embarking on the journey that is transition.

Regardless, some doctors can leave a trans person feeling foolish for their wish to be their preferred gender. According to Ariel, a 24-year-old from Texas who has received hair removal treatment and bottom surgery and has been on HRT for 18 months:

> I checked in and they had me see whatever psychologist was there and she wanted to check me into a psych ward. And that terrified me and got me even more worked up… And it was over at [a Christian hospital] and they were just horrible. They were just horribly inconsiderate.

Ariel was led to think she was crazy and belonged in an institution simply based on her trans status. She describes the health professionals as being "horribly inconsiderate" of her trans status. Ariel's doctors were not sensitive to her situation, which left her feeling uncared for and belittled. It can be hypothesized that if the doctor's had correct knowledge of trans issues, this type of experience would not be a problem. Although,

there are cases where doctors let their personal beliefs influence their treatment of trans individuals. According to Annabelle, a 30-year-old from North Carolina who has been on HRT for two and a half years:

> The first three therapists I went to and told them, they were just kinda like, "No, you're not that. It's not true. You can't have that. That's wrong." Most of them were from a Christian nature so it was kind of, "No, that's not right. You have something else going on." And I'm like, "Yeah, I do have other things going on, but..this is kind of a major thing."

Annabelle had to cycle through three therapists before she found one that did not try to convince her out of her decision regarding her trans status. She describes all three therapists essentially claiming trans did not exist and it was not a proper diagnosis for her. Annabelle suspects their reactions were stemmed from their Christian beliefs. She went in understanding her trans status and that it needed attention. Despite these therapists trying to tell her otherwise, Annabelle was stern about her status as a trans individual.

Imposing personal beliefs on someone's medical care seems inappropriate and offensive. However, this concept of invasiveness, and other related ones, does indeed happen to trans individuals in healthcare. Below, the subtheme, Invasive, is defined and exemplars are provided to demonstrate the experiences trans participants have with invasive doctors.

Invasive. Many participants perceived themselves as victim to a bad experience with an invasive doctor. Specifically, the theme Invasive is defined as participants experiencing doctors who were persistent with asking inappropriate or irrelevant questions related to their trans status.

An invasive experience with a health professional can leave an individual feeling vulnerable and exposed. According to Rachel, a 23-year-old student living in Texas who has been on HRT for 31 months, "I still get asked, invasive questions pretty regularly, I still get people kind of (pause) not necessarily giving me weird looks, but being treated differently." Rachel talks about how the perceived invasive questions, not just from doctors but from patrons as well, are becoming routine. She also notices how the actions of others are different towards her versus others. In most instances involving invasiveness, people are rude and insensitive. According to Annabelle, a 30-year-old from North Carolina who has been on HRT for two and a half years:

> He was extremely pushy with other things too, so it was kinda. I'm tired of going cause you know how I feel about this stuff, like for example. He was very pushy on SRS. He was like, "So when are you getting SRS?" "I've told you five times now, I do not want it." And he's like, "You know, you're probably at the stage, you should probably go ahead and get it." That's not an important factor to me.

For Annabelle, her doctor insisted she needed to complete her transition by getting Sexual Reassignment Surgery. However, for Annabelle, and a lot of trans individuals like her, there is no set frame for a "complete" transition. Transitioning genders is an incredibly delicate process and the decision to transition in any capacity is a personal choice. Because gender falls along a spectrum, not all trans individuals feel the need to go forth with surgery. Despite her making it clear to her doctor that she did not wish to have SRS, he continued to push her in the direction of the major surgery.

Doctors can have the tendency to push certain treatments on individuals, or even to answer certain questions. According to Kevin, a 34-year-old clinical psychologist in North Carolina who has received top surgery and has been on HRT for three and a half years:

> You know, I take meds. And I had a psychiatrist that asked me about (pause) really invasive questions about my sexual history and…you know, he- at the end of the session, other than asking me about what I don't like about a penis going into my vagina…He said, "Well its my job as a Christian to save you." And on his website he says he's LGBT-friendly… And he did not understand the concept of trans but…you know that was the worst experience I ever had.

Kevin describes his worst experience with a health professional when the questions he was asked were incredibly personal and unrelated to his trans care. Sometimes the questions a healthcare professional asks can come from a curious nature, but does not seem to be the case in this situation. Instead, Kevin's psychiatrist placed him in an exposed position and then seemed to introduced his Christianity as a reason for his invasive questions despite having "LGBT-friendly" listed on his website. Deceiving trans individuals, and others that identify with the LGB community, is unacceptable behavior for doctors.

Some doctors might think they are LGBT-friendly or know how to treat certain individuals within this community, but they are actually oblivious to how to care for them, especially trans individuals. These doctors could easily be described as ignorant. Below, this next subtheme is defined and exemplars are given showing how the ignorance of some doctors.

Ignorant. The last type of bad experience discussed by participants is that of an ignorant doctor. In particular, this subtheme is defined as participants experiencing doctors who seemed to be close-minded and gave no opportunity or sign of educating themselves to treat trans individuals; ignorant to trans issues. Included in this subtheme are two subthemes: a) Go Elsewhere and b) Change After Status. Below, exemplars are

provided to demonstrate the ignorance of doctors, the two included subthemes are defined and exemplars are given for each.

Many trans individuals find themselves in situations with a doctor that has no knowledge and no wish for knowledge of trans issues. This minimal level of education, or complete lack of education, about trans healthcare paired with discourteous behavior makes a doctor ignorant. Some participants had never been given the opportunity to meet a doctor that did not demonstrate ignorance. According to Janice, a white 56-year-old in Texas who has been on and off HRT for 11 years, "I just don't feel like there's any physicians that I've heard of, that I've talked to, or anything else, that are totally open-minded enough to accept anybody out of the LGBT community. And trans would be on the very end of that list." Janice does not discredit any doctor who accepts and treats trans individuals, however she doubts the full acceptance and open-mindedness of any doctor she has encountered. In her experiences, she has yet to meet a doctor that accepts the cases of LGBT people, especially trans individuals. Janice recognizes that the acceptance for LGB people in healthcare has improved, however there is still a long way to come for trans individuals. Even a doctor with whom a trans patient has over twenty years of rapport with cannot be assumed to be open-minded enough to accept them. A similar situation also happened to Brandon, a 36-year-old graduate student in Texas who has been on HRT for one month:

> And so, when I went to my regular doctor and told him that I was transgender and that I wanted to get on hormone treatment. His reaction was (pause) shock. He has been my doctor since I was 12 and I was in my 30s when I came out to him. And so to him, I am nothing but female. And so he didn't see any of this male stuff in me and so that not passing was very difficult at that time. And he didn't- he didn't want to acknowledge that something was going on and so it was time to seek different medical care.

For Brandon, his long-time doctor chose to be ignorant to his trans status when Brandon tried to disclose to him. Brandon's doctor made the decision to ignore anything trans about him and only wanted to see him as the female he had treated for many years. At that point, Brandon decided to seek healthcare elsewhere knowing he would not receive the healthcare he needed related to his trans identity.

Sometimes doctors continue to treat trans individuals with improper knowledge of how to do so. According to Rachel, a 23-year-old student living in Texas who has been on HRT for 31 months:

> But like, its *really* common for doctors to blame any sort of- like almost any sort of thing on…your hormones…Like, kind of in the same way that overweight people have to deal with doctors putting everything on the weight… so- I-I would like for them to kind of have…not only like just kind of more knowledge but also less fear and uncertainty and kind of ignorance-based…knowledge, because there's a lot of really- there's a few really pervasive (pause) just like…just completely wrong ideas about you know, transgender bodies and transgender health.

Rachel recognizes that a lot of doctors could change for the better by gaining a more accurate understanding of how to treat trans bodies. A singular perception of trans health and how to treat a trans individual could make for a huge shift in trans healthcare. As Rachel mentions, there are many different ideas surrounding trans healthcare, most of them being false.

Due to the ignorance of many doctors, trans individuals are forced to find healthcare in other places. However, ignorance is not the only factor that pushes trans individuals to seek alternate healthcare treatment.

Go Elsewhere. A few participants had doctors that explicitly sent them to find other doctors that would treat them. Specifically, this subtheme is defined as participants

being sent to other places by their doctor because they were not welcome and refused healthcare treatment.

When a trans individual chooses to disclose to an individual, especially a doctor, they would hope to expect compassion and acceptance. However, this is certainly not always the case. According to Carl, a 55-year-old living between Texas and Massachusetts who has been on HRT for 11 months:

> I went to the primary that I'd been with for several years. And said uh, "Well…(sigh) the reason for all that depression and all that suicidal stuff in my past, I've discovered you know, its cause I'm trans and transgender and I was wond-" You know, its like, I didn't get through transgender. I was gonna ask her if she wanted to supervise T, but I didn't get past that before she said she thought I might do better elsewhere, so.

Even with a doctor he had been seeing for several years, Carl was turned away. He attempted to invite her into his new and exciting process of transition, but did not have the chance to finish his sentence before she rejected him. Rejection is a sad truth, and a degree of ignorance, many trans individuals are forced to face. According to Harold, a 33-year-old performer living in New York who has received top surgery and has been on HRT for seven and a half years, "I just called office to office and I said, 'I'm transgender. I'm looking for care. Will your office provide me with this?' And I just got, No, no, no, no, no, no." Harold experienced a heightened level of rejection from doctor's offices. This level of rejection described by Harold proves the amount of difficulty a lot of trans individuals have in finding a proper healthcare provider.

Another common worry among trans individuals is how they are going to be treated by doctors in an emergency situation or with an unfamiliar healthcare

professional. Many trans individuals describe these experiences as fine up to the point their trans status is discovered.

Change After Status. In their interactions with their healthcare professionals, some participants experienced an obvious shift in behavior from the healthcare professionals. Specifically, this subtheme is defined as participants experiencing doctors making a conscious decision to switch their use of proper pronouns or general behavior in care based solely on finding out the participant was trans.

Especially in instances of unexpected trips to a medical facility, trans individuals experience a higher amount of anxiety surrounding the worry of how they are going to be received. According to Larry, a 43-year-old student from Texas who has been on HRT for 5 years and has received top surgery and a hysterectomy, "I've had more trouble because my documents didn't line up…And so I would go in passing and then once they pulled up my record, then my old name popped up….and then all of a sudden, they would start calling me she." For Larry, who passes as male, his only issue is with his medical documentation. Once a healthcare professional sees his documents list him as anything but male, they immediately change their use of pronouns. As expected, this can be a frustrating experience to see an obvious shift in behavior based on a gender marker. Karen shares this particular experience.

Participants were able to instantly recognize the shift in their doctor's behavior. According to Karen, a Hispanic and White 27-year-old from Texas who has been on HRT for nine months, "He was completely nice and it was congenial and he, up until the point where he just decided that, I lost up to the point where he found out that I was transgender and once he found that out he was blowing smoke." Prior to finding out she

was trans, Karen's doctor treated her like he should have—nice and kind. However, after her trans status was revealed, his demeanor completely changed. Karen describes her doctor as "blowing smoke" meaning that he was wasting time by making senseless comments surrounding her trans status, avoiding the treatment of her overall health. It can only be inferred that this immediate shift in behavior towards a person comes from a place of bigotry, or ignorance.

Theoretical Analysis. Above, the major theme, Bad Experiences, and its four subthemes, Uncomfortable, Doubting Sanity, Invasive, and Ignorant, are discussed. From a co-cultural perspective, participant's bad experiences in healthcare serve two roles. First, these bad experiences reproduce the social hierarchy, placing healthcare professionals in the position of power thus, strengthening the position of participants as a muted group. Doctors utilize their discourse to continually keep participants in a subordinate position, stripping them of any social power (Burnett, Mattern, Herakova, Kahl Jr., Tobola, & Bornsen, 2009; Camara & Orbe, 2010).

Second, participants are able to connect and to strengthen as a community based on these bad experiences. Despite having different types of bad experiences, participants share the same standpoint as a trans individual and thus have shared experiences that they can discuss and attempt to organize how they view themselves and the world around them (Castle Bell, Hopson, & Ross, 2015; Matsunaga & Torigoe, 2008; Ramirez-Sanchez, 2008). Being able to associate with the community through these individual experiences aids in creating a stronger self-concept as a trans individual.

Although a majority of the participants have suffered through bad experiences involving being uncomfortable, having their sanity doubted, and being privy to invasive

and ignorant doctors, many have also had good experiences. Below, the subtheme, Good Experiences, is defined and exemplars are provided.

Good Experiences. Several trans individuals have had the opportunity to have good experiences when interacting with their health professionals. Good experiences are defined as those experiences that involve a doctor leaving their trans patient feeling like they are cared for in terms of their physical, mental, and emotional health. The theme, Good Experiences, emerged through conversation with participants as they responded to the following questions, "Does anything about the doctor, or the doctor's office makes it easier for you to discuss your trans identity, transitioning, or your transition process?" Of the nineteen total participants interviewed, seventeen participants reported having a good experience with their doctor or healthcare professionals. Under this major theme, Good Experiences, there are three subthemes: a) Thorough Doctor, b) Supportive and Accepting, and c) Affirming. Below, each of the subthemes is defined and exemplars are provided for each.

Thorough Doctor. One specific type of good experience involves a thorough doctor. This subtheme, Thorough Doctor, is defined as participants experiencing a doctor that was comprehensive in asking questions and showing care for their full health, checking everything off of the list.

Knowing that the doctor is going to provide treatment along certain standards can serve as a set up for a good experience for any trans individual. According to Linda, a retired police officer in her 50s who has been on HRT for three years and has scheduled her bottom surgery:

> So, I went down there and I got an appointment, it was a few weeks out. So I had copy the Benjamin Standards off of WPATH and- and when I went in to see my endocrinologist, I had my papers in my hand. She walked in the door and she had her copy of the Benjamin Standards. So, and we both just started laughing right from there, right from the beginning because we were both on the same page. You know. Uhm, even though I was her first trans, we both knew where we had to start and so…she started me off real slow.

Despite being her first trans patient, Linda's doctor knew in what places to start looking in order to properly treat Linda. They both entered the appointment with a copy of the Benjamin Standards for trans healthcare and because of this they were able to establish a level of comfort.

Linda appreciated having a doctor that was honest about her level of knowledge of trans medical care and was willing to go through the steps of her transition at a comfortable pace for everyone involved. It can also be comforting to have doctors who have their own particular standards before providing care. According to Conner, a white 29-year-old from Texas who has been on HRT for four months:

> She made sure that all my- all of her concerns for my health were taken care of before I started the transition…she sat and made sure that I knew what I was getting into. And that I had been going to counseling and that I was involved in counseling at the time…cause she wouldn't do it if I wasn't involved in counseling.

For Conner, having a doctor who was not willing to start him on his transition process until he met her requirements was reassuring. His doctor wanted to be as thorough as possible to ensure Conner knew what decisions he was making. Conner's doctor was concerned with his overall wellbeing, which contributes to feeling like his doctor is thorough.

Requiring a patient to go to counseling before starting transition shows care for not only the physical health, but also the mental and emotional health. According to

Larry, a 43-year-old student from Texas who has been on HRT for 5 years and has received top surgery and a hysterectomy:

> I respect my doctor because she's willing to, you know, track it down and go through all these stages. And say, okay you're a transgender male, so we have to look at both of those parts and pieces, but she does it in an open and honest way so that I don't feel uncomfortable like you're going, "Well I'm gonna look at your girl parts, just because." But that's not fair, but she just-she explains it to me in the, "You are a complex individual as all individual are and I really want to look at the full picture."

Larry expresses the respect he has for his doctor because she is methodical in how she treats him. His doctor's openness and honesty in how she is going to care for every aspect of his mental and physical health aids Larry in developing respect and appreciation for his doctor. Larry's doctor focuses on his trans status as trans, rather than as a spectacle to be gawked, which validates the experience of the mind and body and therefore, the transition process. Larry takes a role in his healthcare because his doctor takes the time to explain her methods to him, emphasizing treating the whole person and realizing the intricacy in treating a trans individual.

A thorough doctor can be a huge benefit to any person. For a trans individual, a thorough doctor helps the progress of the transition process when they cover all possible side effects and consider the whole person when providing treatment. More often than not, having a thorough doctor involves having an understanding doctor that is encouraging of transition. Below, the subtheme, Supportive and Accepting, is defined and exemplars are given to illustrate how participant's doctors were supportive and accepting.

Supportive and Accepting. Some type of support group can be a significant part of having a healthy transition and overall life. When the doctor is included in this group,

it makes transition much easier. Specifically, this subtheme, Supportive and Accepting, is defined as participants experiencing a doctor that was supportive or accommodating and accepting of their trans status, thus making for a good experience.

Having a bad experience previously can help a trans individual value a good experience more. Whether it is just a regular doctor's visit or during a surgical visit, a supportive and accepting doctor can make all the difference. According to Wade, a 20-year-old student living in Washington State who has been on HRT for one and a half years and has received top surgery, "Yeah, like my breast reduction was done by an Adventist surgeon in an Adventist hospital. None of them thought I was nuts. All of them were excited and supportive…[The doctor] came out and said, publicly he would [work] more [with] trans, openly." Wade describes his surprise in finding a team of supportive healthcare professionals in a traditionally religious medical facility. He went into the healthcare environment expecting his doctors to treat him one way, but to his amazement, he received an impressive level of care. Even further, his surgeon expressed interest in performing more surgeries for trans individuals, which seemed to demonstrate a high level of support and acceptance for the trans community.

Through a good experience, participants can realize the privilege they have in receiving the type of care they receive. According to Brandon, a 36-year-old graduate student in Texas who has been on HRT for one month:

> He was very excited about the process and didn't show any negative signs or anything and you know, I've heard *horror* stories from other transgender people about the medical experience. And he just was right on board and right with it, and very positive. So I was pleased with that.

For any trans individual, going through transition can be an exciting process, but having a supportive doctor can make it even more enjoyable; this is the case for Brandon. He describes his doctor as being enthusiastic about his transition and generally positive. Having a doctor who exemplifies these attributes can potentially help a trans individual look forward to seeing their doctor. According to Sophie, a 47-year-old computer programmer in California who has been on HRT for four months, "You know, my doctor knows- she's- she's my-my advocate. She's my- I feel very supported by her and by the doctors office…I mean I actually enjoy going to the doctor's office." Sophie specifically describes her doctor as her advocate, meaning her doctor fully supports her transition decisions. Her doctor supports her and the entire trans community publicly, which means a lot for a trans individual in terms of verification of their trans status.

A supportive and accepting doctor can be a reassuring experience for trans individuals. These types of doctors can help a trans individual to feel validated in their transition. Below, the subtheme, Affirming, is defined and exemplars are provided.

Affirming. The last type of good experience comes in the form of an affirming doctor. Specifically, the theme, Affirming, is defined as participants experiencing a doctor that validates their trans identity, encouraging transition steps and recognizing the progress being made. When a trans individual comes to the realization that they are indeed trans, having a doctor confirm this diagnosis creates a good experience for the trans individual. According to Brenda, a 70-year-old retired press operator in Washington State who has been on HRT for three years:

> And they're medical professionals now, they- the doctors, the gender doctor I had- I had in Seattle I still have, is one of the most…life affirming people I have ever known. I mean, you walk into her office and she just radiates, "Everything is

> going to be okay!" She's one of those-one of the top gender people in Seattle, which is saying a lot.

Brenda describes her gender doctor as providing the most life affirmation she has ever experienced. Walking into an appointment and knowing care is going to be provided, in all aspects of healthcare, can be an empowering experience.

At some point, when an individual has been with their doctor for so many years, it becomes a routinely enjoyable experience visiting the doctor. According to Carl, a 55-year-old living between Texas and Massachusetts who has been on HRT for 11 months, "When I go see Steve, I'm going to see a friend, you know at this point." Carl describes his doctor as a friend, even calling him by his first name. This kind of relationship typically comes with time and a level of affirmation that produces the environment capable of building a friendship. Just one affirming doctor experience can shift a trans individual's entire view on healthcare professionals. According to Kevin, a 34-year-old clinical psychologist in North Carolina who has received top surgery and has been on HRT for three and a half years:

> She picks up on the subtleties, even though having a beard isn't all that subtle…But she *sees* me, she sees *me*...I'm not sure what the hell it is, but um. She sees me, and it's amazing. I mean I have very few healthcare related experiences that I can draw upon. But, I feel like of all the people, like she picks up on the subtleties.

For Kevin, he placed heavy emphasis on the fact that his doctor possessed the ability to look past the physical and see him for who he is, male. His doctor, possibly unknowingly, has provided Kevin with the affirmation he needs to continue in his transition and feel complete as a human being. Affirming doctors are a significant contributing factor to the overall health of trans individuals.

Theoretical Analysis. One good experience with a doctor, whether they are thorough in their care, supporting and accepting of trans status, or affirming of trans identity, can give trans individuals the empowerment to tread the transition process confidently. Above, the major theme, Good Experiences, and its subthemes, Thorough Doctor, Supportive and Accepting, and Affirming, are discussed. From a co-cultural perspective, this theme is beneficial in two ways. First, the power structure shifts when a good experience is shared between a participant and their doctor. The communication between participants, as co-cultural members, and their doctors, as dominant group members, is influenced by power (Castle Bell, Hopson, & Ross, 2015). Therefore, during these good experiences, doctors still serve as the dominant group member when interacting with trans patients, however the power status is split between the doctor and the patient; doctors release a portion of their social power to the patient. This shift in power can improve a participant's standpoint due to the positive experience within their social location (Castle Bell, Hopson, & Ross, 2015).

Second, as participants encounter positive experiences in healthcare their self-definition begins to improve, thus their standpoint changes. This means as participants begin to cultivate their standpoints and a doctor leaves an encouraging impression their self-defined standpoint is more profound than it was before (Parker, 2002). Participants start to see their social location less as an outsider or minority and more as a contributing member of the general society.

More good experiences with doctors are needed for trans individuals. Below, the theme, Advice for Doctors, is defined and exemplars are given to describe the types of advice participants felt they needed to provide doctors.

Advice for Doctors

Based on the many experiences participants have had in the healthcare context, many of them have come to learn what they would like to see in their doctors and doctor's offices. The theme, Advice for Doctors, is defined as participants mentioning ways they wish their doctor or doctor's office treated them or how the environment could be more welcoming or comfortable. This theme emerged organically through conversations with participants about their experiences with their doctors. Of the total nineteen participants, thirteen offered a form of advice for doctors. Under this major theme there are two subthemes categorizing the types of advice participants described: a) Personal Behavior and b) Office Logistics. Below, each subtheme is defined and exemplars are provided.

Personal Behavior. Many of the ways a healthcare environment can be improved involved the personal behavior of the healthcare professionals. Specifically the subtheme, Personal Behavior, is defined as participants describing ways in which their doctors and office staff could change their behavior to make the health environment easier to enter. There are three subthemes included: a) Acknowledge if Necessary, b) Pronoun Usage, and c) Asking Questions. Below, each of the subthemes is defined and exemplars are given to demonstrate the ways these types of behavior can be improved.

Acknowledge if Necessary. One way doctor's can shift their personal behavior in the office is to only acknowledge a trans individual's trans status if necessary. In detail, this subtheme is defined as participants recommending doctors recognize their trans identity if it is relevant to the healthcare being provided. This specific subtheme emerged

through conversation when I asked participants, "Do you want doctor's to acknowledge your trans identity?"

Like any other cisgender person, trans individuals would typically like to be treated as their preferred gender. However, there are some visits that require the acknowledgement of a trans status. In direct response to the question, "Do you want doctors to acknowledge your trans identity?" Conner, a white 29-year-old from Texas who has been on HRT for four months, stated his wants, "If it's necessary to what I'm going to see them for." If his visit involves something related to his trans identity, Conner wants his doctors to bring his trans status into the conversation. Otherwise, Conner does not feel his trans identity has a place in the conversation about his healthcare.

Larry shares the same sentiments as Conner. According to Larry, a 43-year-old student from Texas who has been on HRT for 5 years and has received top surgery and a hysterectomy, "There's certain times that its relevant. I mean, if I'm going in there because I'm have a pain in my pelvic region, then yes, by all means lets discuss the fact that I'm a transgender male." Larry is more specific in detailing the regions of his body that are related to him being a trans male. He emphasizes there is a time and a place to bring up his trans identity and this only includes when he goes to a visit with pain or concern surrounding a related area of his body.

Some participants took issue with the application of their trans status in a conversation about general healthcare. Other participants had concerns with how there are approached in terms of pronouns. Below, the subtheme, Pronoun Usage, is defined and exemplars are provided to describe how participants would prefer to be addressed.

Pronoun Usage. Many trans individuals face being referred to by their biological pronouns on a daily basis. In the doctor's office though, many participants would expect a higher level of understanding. This subtheme, Pronoun Usage, is defined as participants expressing their preferences in terms of pronoun usage with the doctor and other healthcare professionals.

As a platform for better understanding, participants provided their opinions on how they would like to be treated, in terms of pronoun usage, in the doctor's office. According to Linda, a retired police officer in her 50s who has been on HRT for three years and has scheduled her bottom surgery, "I want to be called she, you know. I don't want them to- when they call me from sitting out in the lobby and…I don't want them to say hey transgendered Linda, will you come over here. No, I want she- I mean, come on ma'am." It is rare that a doctor's office treats exclusively trans individuals, thus many trans individuals visit doctor's offices that see cisgender individuals as well. Calling a trans individual by the non-preferred pronouns is essentially disclosing their personal identity to those around them in the waiting room, as Linda mentioned. She talks about how she simply wants to be called by "she" because this is how she identifies.

In some instances, it is not just a matter of using the preferred pronoun, but also being consistent with pronoun usage. According to Jaston, a Palestinian American 25-year-old living in Texas who has been on HRT for 20 months, "Stay in line with the pronouns that I prefer…treat me like a normal human being. Get to the point and don't try to prescribe me anything that I don't need." Jaston provides doctors with several recommendations essentially summarizing how he would like to be treated like any other

human being. Behaving in an odd way with trans individuals can make them feel like even more of a minority than what society has already established.

Using the preferred pronouns when talking with or addressing a trans individual can be vital for doctors and healthcare professionals. Another behavior change that participants suggested was how to and what types of questions to ask. Below, the subtheme, Asking Questions, is defined and exemplars are provided to demonstrate what participants urge doctors to change.

Asking Questions. It is natural for any human to be curious about something they do not know very much about. However, there are certain questions that are appropriate to ask to trans individuals and others that are not. Specifically, this subtheme, Asking Questions, is defined as participants sharing their advice on the types of questions doctors should ask and more importantly, how these questions should be asked.

Many questions can come from a pure place of curiosity, although the ways these questions are asked are key to whether a trans individual feels comfortable or not. According to Jaston, a Palestinian American 25-year-old living in Texas who has been on HRT for 20 months:

> And I guess like (pause) for-for…doctors, you know, people in the-the-the health field. Dealing with trans people, ask the simple questions first. Like, "What do you identify with?" You know, "What pronouns do you prefer?" And let (pause) I guess, don't get too- I know this sounds kinds of weird- but don't get too nosey as far as…emotional, you know, transitioning, and stuff like that. And that's like- that's something that I've known…other trans people to kind of get uncomfortable about.

Jaston advocates asking simple questions that are directly related to the current healthcare being given. He suggests doctors be interested in the trans person, rather than the person being trans as a spectacle. Jaston even reports knowing that other trans individuals he

knows get uncomfortable when doctors try to ask irrelevant questions about their transition. Asking sensitive questions can be a challenge for doctors. According to Larry, a 43-year-old student from Texas who has been on HRT for 5 years and has received top surgery and a hysterectomy:

> We need to let doctors-have doctors know that…creating these conversations and saying, "Hey we are gonna have this delicate conversation, I'm gonna ask you some questions. Are-do you have preferred words that you want to use to make this an easier conversation. What do you call this part of your body…do you call it anything because you know, hey if we don't check it something could go wrong and we're not gonna find it til you're- you're way on down the road in third or fourth stage cancer. Whether it is prostate, whether it is…cervical cancer or breast cancer, or whatever the case may be."

For Larry, he suggests letting doctors be aware to start the conversation by establishing a mutual terminology. Creating a shared understanding that a conversation could potentially be uncomfortable and forming a common vocabulary can help make the needed conversations easier. As Larry mentions, without this modification in healthcare professional's behavior, serious health issues could be missed or overlooked.

Making these simple changes in behavior could significantly improve the healthcare experience for trans individuals. Other participants made suggestions as to how doctor's offices could change a few logistics to improve their care for trans individuals. Below, the subtheme, Office Logistics, is defined and exemplars are provided demonstrating the ways offices could make changes.

Office Logistics. Another way healthcare can be improved for trans individuals, as described by participants, is to change the way the office approaches the trans community. Specifically, this subtheme is defined as participants explained ways the office organization could be changed to make the initial contact with the office easier for

trans individuals. Included are two subthemes: a) Intake Forms and b) Website Changes. Below, each subtheme is defined and exemplars are provided.

Intake Forms. A common barrier to feeling comfortable in the doctor's office, for trans individuals, starts with the paperwork. This subtheme, Intake Forms, is defined as participants expressing interest in changing the preliminary paperwork to include more than just the binary genders, male and female.

Most of society only sees two genders, male and female, and this is reflected on most forms filled out. When gender is asked of an individual, they are asked to mark either male or female. According to Harold, a 33-year-old performer living in New York who has received top surgery and has been on HRT for seven and a half years, "And…in Georgia. And it was the first place that I went to where you could put trans as [an option]. I was shocked." Harold, unlike most, experienced the option of marking that he was trans on an intake form when visiting the doctor. Noting that this experience occurred in Georgia provides hope for other generally conservative areas of the United States.

Giving trans individuals the option to mark if they are trans on an intake form can make the encounter much easier and smoother for both the trans individual and the doctor. One participant even said that she told her doctor directly about the benefits of making this change. According to Meli, a Pacific Islander and Latin web developer in Washington State who has been on HRT for nine months, "At the medical community and that's something I told my physician, that she should do is- is to have that as something as an option on the intake forms." Meli told her doctor that she should make this change to ultimately make it more inviting and relaxing for other trans individuals.

Some participants cannot get past the intake form to ever feel at ease when visiting the doctor. According to Brandon, a 36-year-old graduate student in Texas who has been on HRT for one month, "It's that intake form, right off the bat, that makes it difficult." Brandon expresses how uncomfortable a healthcare visit can be simply by the intake form and its lack of gender options. He finds the healthcare environment a difficult place to exist because the intake form assumes his gender does not exist. Making this simple change to all intake forms, and other forms demanding gender identification, can make for a much better experience for trans individuals. Although, there are other modifications that can be made to make trans individuals more comfortable, even before a foot is stepped in the doctor's office. Below, the subtheme, Website Changes, is defined and an exemplar is provided to support the suggestion.

Website Changes. A lot of participants stated they did myriad research online prior to talking with a doctor. A simple modification in certain websites could make it easier and faster for trans individuals to find those doctors that are going to treat them in the desired respectful ways. Specifically, this theme is defined as the recommendation to clearly state the specializations, or what communities are worked with, of a doctor on the website of a clinic or hospital.

Adding these adjustments to a website can make it much more inviting for any trans individual to visit a doctor's office. Many doctors can profit from enacting this adjustment to their website by gaining many new clients. According to Meli, a Pacific Islander and Latin web developer in Washington State who has been on HRT for nine months:

> I think a doctor can also…really benefit if like my therapist says a lot of other therapists who put down, who have a website and then they put down their specialties, when they write down, they say…that they…specialize or they work…closely with the…transgender or those that suffer from gender identity dysphoria, gender identity disorder, GID or gender dysphoria. To make those, like myself…feel comfortable knowing, "Okay, this is somebody I can talk to."

Meli describes how a trans individual can be made to feel more comfortable prior to the very first visit to a doctor's office. Even by replacing the term transgender with those who suffer from Gender Identity Disorder, or GID, can make it more welcoming for trans individuals. Trans individuals will feel as though they can go to a particular doctor for healthcare if this simple alteration is made.

Theoretical Analysis. Above, the major theme, Advice for Doctors, and its two subthemes, Personal Behavior and Office Logistics are discussed. By endorsing the recommended changes above, participants have a greater chance of achieving healthy co-cultural communication with their doctors. Defined, *healthy co-cultural communication* is positive and affirming interactions between traditionally marginalized group members and dominant group members (Orbe, 1998b). Specifically, for participants, this means having a doctor that treats the whole person in a respectful and attentive manner.

Doctors that are interested in contributing to a healthy co-cultural communication climate can choose to treat their trans patients according to the biopsychosocial health model viewing the physical, mental, and emotional health factors as equally important. Also adding to a healthy intercultural communication climate, doctors can adopt the modifications suggested by participants. By enacting these changes, doctors can significantly improve the communicative reality for trans individuals who visit their office.

Each of the seven major themes and their accompanying data has revealed an important understanding of the trans community. First, language is important. How people refer to trans individuals and the discourse used to describe members of the community matters. The best option is to always ask each individual what language they prefer. Second, trans individuals want to be treated as any other human being, with respect and dignity. Support from friends and open communication with their doctors has helped the achievement of their overall healthcare goals. Fears and outright avoidance has prevented trans individuals from achieving their overall healthcare goals.

Third, location definitely matters because it helps determine the level of healthcare a trans individual receives. Fourth, trans individuals utilize nearly every strategy in co-cultural theory. They use the strategies to navigate their way through an interaction with a healthcare professional. Fifth, there are always going to be doctors that disagree, for their own reasons, with the trans body and will choose to never treat them. This does not mean the majority of practicing doctors are not willing to learn about trans healthcare. Sixth, participants have laid out the type of doctor they like and dislike through their description of the good and bad experiences they have had with their doctors. Finally, participants want doctors to learn and be better physicians and some are willing to tell them what to do to help improve their practice.

CHAPTER V

DISCUSSION

In the following chapter the major concepts of this thesis are reviewed and discussed. First, the major themes and subthemes are reviewed. Second, the theoretical implications of this major project are presented. Third, the limitations of this study are given. Fourth, I discuss what I have learned in the larger scope of this study. Finally, the areas for future research are offered.

Participant's reported experiences fell into one of seven major themes: 1) The Concept of Passing; 2) Overall Healthcare Goals; 3) Location Matters; 4) Co-cultural Strategies; 5) Incompetent Doctors; 6) "Good Doctors are Good and Bad Doctors Suck"; and 7) Advice for Doctors. Of these seven major themes, five had at least two subthemes. The first major theme had no subthemes, instead exemplars were provided to demonstrate the legitimacy of the major theme. The second major theme, Overall Healthcare Goals, had two subthemes: a) Helped and b) Hindered. The third major theme, Location Matters, also had two subthemes: a) Advantage and b) Disadvantage. The fourth major theme, Co-cultural Strategies, had five subthemes including a) Emphasizing Commonalities; b) Communicating Self; c) Rationalization; d) Maintaining Barriers; and e) Educating Others. The fifth major theme had no subthemes, however exemplars were provided. The sixth major theme, "Good Doctors are Good and Bad Doctors Suck," had two subthemes: a) Bad Experiences and b) Good Experiences. Finally, the seventh theme, Advice for Doctors, had two subthemes: a) Personal Behavior and b) Office Logistics.

Theoretical Implications

As a theoretical framework, co-cultural theory (Orbe, 1998a) helped to create the theoretical analyses. Included in the theoretical analyses are muted group theory (Kramarae, 1981) and standpoint theory (Hartsock, 1984). With these three theories in mind and the theoretical analyses provided for each theme in chapter four, three major theoretical implications are provided.

First, co-cultural theory can help trans individuals achieve the desired level of healthcare, or at least explain why they do not already receive a perceived decent level of healthcare. This is evident in the major themes Overall Healthcare Goals, Location Matters, and Advice for Doctors. Trans individuals are provided, through co-cultural theory, a list of possible outcomes and approaches to achieving the desired healthcare. Standpoint theory helps to explain how a trans individual's geographical location helps to determine the level of healthcare they receive. The participants in this study offered several pieces of advice to doctors as whole, stating what they can do to improve the healthcare experience for trans individuals.

Second, the reinforcement of social power and social hierarchy are distinct in parts of the data. Specifically, the themes The Concept of Passing, Incompetent Doctors, and Bad Experiences speak to this theoretical implication. Through the use of language, doctors, being the dominant group, enact their social power and fortify the social hierarchy present in society. From using the non-preferred pronouns to acknowledge a trans individual, to demonstrating a level of perceived incompetence during an interaction, to creating an overall bad experience for the trans patient, all instances involve the element of discourse.

Finally, co-cultural theory helps to explain the experiences of trans individuals. To date, co-cultural theory has been applied to nearly all demographics, excluding trans individuals. Through this study, co-cultural theory successfully illuminates the experiences for trans individuals in the healthcare environment. Specifically, the Co-Cultural Strategies theme, with the five highlighted strategies, give insight into how trans individuals use the strategies that help build the foundation for co-cultural theory.

Limitations

Every study has an imperfection that can be altered to potentially make the study better, more meaningful, or easier to conduct. This major project has two main limitations to present.

First, the term "transgender" itself served as a source of confusion and miscommunication. There are primarily two understandings of the term. Transgender often serves as an umbrella term encompassing many gender identities including genderqueer, bi-gender, and agender, among others. Here, transgender is used to describe a community as a whole. The second understanding is transgender as describing a person: one who feels as though they were born in the wrong body and therefore seek medical treatment to transition between sexes. This confusion in understanding is what led to the inability to fully interview one participant. When studying this population, it is important to distinguish exactly the type of sample being sought.

Second, the location of the participants and the type of interview context in which the interviews were conducted poses a limitation. The majority (12) of participants were located throughout Texas and yet only three of nineteen interviews were conducted face-to-face. The ability to travel to varying states and collect interviews, all face-to-face,

could considerably change the results. Although every trans individual has a different set of experiences in their healthcare environment, their location can contribute to the type of healthcare they experience. In this case, a large portion of the twelve participants residing in Texas had similar, negative healthcare experiences to share.

Gained Knowledge

From this first major study, I have gained four understandings about the trans community. First, doctors need more education. A basic level of education surrounding trans healthcare treatment is needed. Regardless of the personal views and beliefs of the healthcare professional, a part of their job is to care for their patients in all appropriate capacities. I think doctors will continue to learn from their trans patients, however a base level of understanding could help prevent participants from feeling the obligation to fully educate their doctors and in turn, represent the trans community as a whole. Every trans individual's experience is different and some individuals require a different level of care when considering the other ailments that may be present. For instance, one of my participants shared that she had fibromyalgia and yet the doctors could not tell her how her transition treatments were going to clash, if at all, with this other illness.

Second, the overall feeling I get from participants is that they are hopeful and determined to find the right doctor that will treat them with respect and provide the best healthcare possible. This community of individuals is very strong and inter-connected; they depend upon one another for support and advice when going through the transition process. Although some participants had only had good experiences in healthcare and others only bad experiences, the majority had a mixture and had to step over the bad doctors to find the great ones. These people just want to be who they are without ridicule

or judgment, especially from their doctors whom are expected to be cordial and accepting of at least their trans body in terms of giving proper medical treatment. Most trans individuals are willing to work with their healthcare professionals and help their level of education, at least from their perspective, so long as the professional is willing to discard any discrimination and prejudgment.

Third, the concept of passing is a much larger issue than I previously realized. As an outsider, my understanding was that passing; even the term itself was a widely understood and accepted concept. However, to my surprise, several participants took issue with the language. It had never occurred to me that there was a negative connotation attached to the idea of passing; however, it makes sense. As humans, we cannot help but place judgment on someone at first glance, especially considering gender; it is how we are raised and trained. The binary system casts a giant shadow over anyone that is non-gender conforming. The more recognition queer identities receive, the more the gender binary can begin to be broken down.

Finally, member checking helped me realize that the language used surrounding the trans community is very important, as it needs to be considerate and sensitive. The treatment some trans individuals experience in the medical community or the sheer lack of medical treatment they receive from particular doctors is a surprising reality.

Future Research

There are a couple avenues of future research for other scholars. From this study, I have a couple recommendations as to where to go from here in terms of research within the trans community.

First, this study can be extended to include interviewing the doctors of trans patients. Due to the time constraint in completing this project, I was not able to include interviews of doctors. However, other researchers can interview trans patients and their doctors to include both perspectives of the healthcare of the trans individual. It might even be possible that doctors have advice for trans individuals, just like the participants in this study had for doctors.

Second, since location plays such a large role in this project, primarily in the healthcare context, future research could investigate further into the topic. It can be inferred that the trans individuals who reside in larger cities such as Houston, or more liberally based states, such as New York, typically receive better healthcare because of the behaviors of their doctors. Other scholars can look into interviewing trans individuals in these types of areas to compare the types, or level, of healthcare the trans individuals receive. This type of study could help to improve healthcare for the trans community nationwide by modeling after the more successful regions of the United States.

The above project has shed light on many of the experiences for trans individuals, specifically in the healthcare environment. It is worth mentioning that the conclusions pulled from this study are only representative of those persons who were interviewed. By no means does this data portray the feelings, beliefs, or experiences of all trans individuals. Although there are still instances of discrimination, prejudice, and transphobia, the acceptance and understanding of trans individuals and their health cases is growing. With more changes being made in healthcare to help educate healthcare professionals, the trans community can begin to feel more comfortable about entering the healthcare environment and seeking out proper healthcare.

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APPENDIX A

INFORMATION SHEET

TITLE: Queering the doctor's office: A co-cultural exploration of communication between trans-patients and their doctors.

We would like to invite you to participate in a research project. We hope to learn about your experiences (positive or negative) as a transgender individual, when you visit your doctor's office.

RESEARCH PROCEDURES
If you agree to participate, we will schedule a time to discuss your experiences in an interview. During the interview, I will ask you about your experiences in the doctor's office. Interviews will take between 45 to 60 minutes to complete.

RISKS
Participation in this research will not hurt your physically. However, we understand that talking about being a trans individual in the doctor's office may be uncomfortable. We can stop at any time or skip over questions you don't want to talk about. We think that talking about this subject, even though it may be emotional, will be a positive experience. We will be supportive of you during the whole interview process.

BENEFITS
There are no benefits to you as a participant. However, sharing your thoughts may make you feel better – since you will be able to talk about how you feel when you talk with your doctor.

CONFIDENTIALITY
Only myself and my mentor will hear the interview recordings. After your interview, I will type up everything you said to be sure I did not miss anything you shared. After I type our conversation, I will destroy the audio recording. All typed information will be stored in a locked filing cabinet in the principal researcher's office. We want you to know that your information is private. None of the information can be tied back to you as an individual. You will pick another name to call yourself in the interview. I will refer to you using this name while we talk and when I type the information. Your real name and all conversation details will be very private.

PARTICIPATION
Your participation is a volunteer opportunity and we cannot pay you for the interview.

CONTACT
This research is to be lead by Katy A. Ross under the direction of Dr. Katie Langford. You may contact Katy Ross at (806) 742-3911 or katy.ross@ttu.edu. Dr Katie Langford can be reached at (806) 734-1815 or Katie.langford@ttu.edu. You may also contact the

Texas Tech University **Human Research Protection Program at** (806) 742-2064, they reviewed our research procedures.

APPENDIX B

RECRUITMENT LETTER TO POTENTIAL PARTICIPANTS

Hello,

My name is Katy Ross, and I am a graduate student. I am studying in the Communication Studies Department at Texas Tech University. Dr. Katie Langford (PI) and I (Co-PI) are writing to speak with you about doing an interview for our research project.

We hope to learn about your experiences talking with doctors and nurses during visits to their offices. We hope to learn how being transgender impacts how you speak with your doctor or nurse, if it does at all. If you agree to participate, we will talk with you about positive and negative experiences in the doctors office.

Some questions may be uncomfortable to answer. If you'd like, we can skip questions or stop the interview to make you more comfortable.

Our interview time may take between 45 to 60 minutes. The interview will be audio-recorded with a small tape recorder, because we don't want to miss any information you share during our time together.

We want you to know that your personal information will be private – only the researcher will know your real first name. Also, only the researcher will know your private information. We will shred all personal information, like your name, the interview. You'll get to pick another name to go by in the interview. If you'd like to talk with us, please let me know when a good day and time is to chat.

We hope you will become a member of our study. Please contact one of the phone numbers or emails below to set up a time to talk or if you have any questions we can answer for you. You may also contact the Texas Tech University Human Research Protection Program. They are located in the Office of the Vice President for Research, Texas Tech University, Lubbock, Texas 79409. Or you can call (806) 742-2064 to discuss the study with someone who is not part of the research team.

Sincerely,

Katy Ross	806-742-3911	katy.ross@ttu.edu
Dr. Katie Langford	806-834-1815	Katie.langford@ttu.edu

APPENDIX C

APPROVED INTERVIEW GUIDE

First, we will begin the interview with some general demographic questions that I will need to report. These questions are light in topic content and quick to answer. They will help us begin our larger conversation.

1. How do you identify, in terms of gender?
2. What pronouns do you prefer?
3. How old are you?
4. How much school have you completed?
5. In what state do you have currently live? Where else have you lived?
6. What is your profession or occupation?
7. May I ask you what your estimated annual income is?
8. How would you identify yourself in terms of cultural background or ethnicity?
9. As far as the transition, in terms of time and physicality about how far are you into your transition? (hormones, top surgery, bottom surgery, name change on BC, Passport, DL, etc.,)
10. And are there any other types of transition you'd still like to do?

That's the end of the demographic section. Next, we are going to talk a little about passing as your preferred gender at the doctor's office.

1. Do you feel as though you pass as your preferred gender?

    a. Probe: About how many months or years ago did you start passing as your preferred gender?

2. Can you tell me about the first time you realized you passed as your preferred gender at the doctor's office/in the health context?

3. Ok—the next question is similar. Can you tell me about a memorable time where you didn't pass as your preferred gender at the doctor's office?

    a. Probe: How did you respond?

   b. Probe: Can you think of any other ways you could you have handled the situation?

4. How has your response to passing or not passing in the health context changed over time at all?

DISCLOSURE & COMMNUICATION IN HEALTHCARE

Over the next few questions, I want to talk with you about communication and disclosing your gender identity to healthcare providers (doctors, burses, physicians…)

1. When you decided to transition, who was the first person you shared this desire with?

   a. What made you share your desire with this specific person? Are there any qualities about this specific person that made it easier to share with this person?

2. Did you talk with a doctor about transitioning before you began the transition process?

   a. If YES- In what ways?

   b. If NO (or YES)- Did you inquire any trans-related information, without disclosing your interest in transitioning?

3. This question is similar to the one I just asked you. At what point did you decide to share your decision to transition with your physician? (Biomedical or Bio-psychosocial model)

4. Can you share the first conversation you had with a doctor or nurse about transitioning and your desire to go through the process? (Biomedical or Bio-psychosocial model)

5. Do you currently see the same doctor as before you started transitioning?

   a) IF YES – why did you keep the same physician?

   b) IF NO – A) why did you decide to switch physicians?

GENERAL Co-Cultural Theory QUESTIONS

1. In your life today, would you describe your communication with health professionals as mostly positive or negative?

2. Can you share an experience in a health environment that left you feeling or like it was harassment or discrimination, if you've had one at all?

    a. Probe: How did you respond?

    b. Probe: Was there an alternative way you could have responded?

    c. Probe: Why did you decided to respond in this manner?

3. Overall, do you feel like you have the ability to communicate without anxiety with your health professionals?

    a. Probe: You said yes overall, are there specific instances where you experience anxiety?

4. Do you feel comfortable in the health context? Why or why not?

5. What do you think makes you comfortable or uncomfortable?

6. I'm wondering if anything about the doctor, or the doctor's office prevents you from discussing trans identity, transition, or your transition process?

7. My next question is similar. Does anything about the doctor, or the doctor's office makes it easier for you to discuss your trans identity, transitioning, or your transition process?

8. What are your overall goals when you visit the doctor's office or interact with health professionals? (Reference Preferred outcome goals)

    a. In your personal experience, has anything hindered your goals?

    b. In your personal experience, what, if anything, helped you accomplish your goals?

9. Ideally, when you visit the doctor's office, how would you like your visits to go?

    c. Do you want doctor's to acknowledge your trans identity?

    d. Would you prefer they simply interact with you using your preferred gender?

10. What does a 'normal' or 'healthy' trans patient, doctor visit look like? What would occur in these meetings?

11. How educated do you feel like your doctors are on trans related issues?

12. Can you share a conversation where you felt the need to educate your doctor/nurse practitioner on transgender-related issues?

Trans and Social Media

1. Did you do any research about transitioning online or through another outlet, other than the doctor?

2. Do you find that social media—YouTube, Facebook—played a role in your transition? If so, could you talk about this?

    a. Probe: Did you look at any other parts of social media during the transition process?

    b. Probe: Did social media help shape your personal gender identity?

3. How do you represent yourself on social media—Facebook, YouTube, etc.?

    a. Probe: How did you represent yourself at different stages in your transition?

4. How did social media impact the questions you asked your providers about transitioning, if it did at all?

This is the final question in this interview. As we finish our interview time together today, is there anything that you'd like to add to this conversation?

Are there any final thoughts you'd like to contribute?

Is there anything you feel like people need to know?

Is there any comment you want to make about this interview? Do you have suggestions? Do you have feedback?

APPENDIX D

RESEARCH QUESTION ONE THEME ANSWERS

RQ1: As a co-cultural group, how do transgender individuals navigate communication interactions with their healthcare providers?

THEME	HOW IT ANSWERS	EXEMPLAR
The Concept of Passing	Just like in the general public, the health environment can judge a trans individual based on their appearance, or whether or not they pass as their preferred gender. For some participants, they had explicit experiences of NOT passing while others, like Meli, had memories where they DID pass in the healthcare environment. One of the contributing factors to a participant feeling comfortable with their doctor is if they feel as though they pass, or are accepted as their preferred gender.	Meli: When receptionist staff or-or folks in the waiting room…will like…presume or treat me as though that they presume that [female was my] assigned sex at birth. Um, that's when I started to realize that I, in the health context, that I was passing more than I had even realized that I was…It feels good in *any* situation, um, to feel like you're being perceived as the way that … you're presenting currently.
Overall Healthcare Goals	When participants enter the health environment, they have an idea of what goals they would like to accomplish. They navigate the interaction by either making sure their goals are met or leave the situation feeling disappointed in the lack of achieved goals.	Brandon: Um, always one of my goals is to..(pause) solve whatever the main problem is that I'm there for..I want to address whatever issue is the issue at hand… and then I also want to build this rapport. So that I know I don't have to change doctors every time…And then…the third is that the overall person is concerned, is a concern of the doctor and is an awareness of the doctor. And so the transgender is sort of that part of the overall person.

Overall Healthcare Goals (Helped)	Some participants shared specific things that aided in the achievement of their overall healthcare goals. Specifically, Conner navigates the communication interaction with his doctors by sharing all necessary information. By doing this, he benefits both himself and his doctor because the opportunity for better and more complete care is higher.	Conner: I think realizing that I cant- I have to give all the information I have, like I cant just give part of what's going on with me to the doctor. Like I've had to learn that I have to give every detail of what's going on…because (pause) to me, going through this process is a very sensitive thing. Just…in re- in regards to my health I guess. Just because I'm pushing the border on other health issues that transitioning could cost me to go over.
Overall Healthcare Goals (Hindered)	In some cases, there were things that prevented participant's overall healthcare goals from being accomplished. Participant's, like Brandon, navigated the interaction with fear or false expectations which prevented him from being able to talk with his doctors openly.	Brandon: I know that- that there have been times that I haven't been able to talk to my doctors as honestly as I should be able to and its been because of fears or because of false expectations that I've had.
Location Matters (Advantage)	Location played a major part in how a participant navigated the communication interaction with their doctors. For some, their residing location made the interaction easier.	Jared: I think that a lot- a lot of healthcare professionals, at least in the area of the country that I live in, which is a very small bubble, are really open and excited to learn about trans issues and become more trans competent.
Location Matters (Disadvantage)	For other participants, their location served as a disadvantage. In some instances, participants were forced to seek healthcare in a far away city or learned to	Rachel: Especially kind of in this area…you have this expectation when you go into a lot of kind of like, professional contexts…that you're being ignored,

	expect a particular level of care, like Rachel.	talked over, that your concerns are going to be disregarded. Or that you're just going to get made fun of or harassed.
Good Experiences	The behavior of a doctor can determine how comfortable or supported a participant felt. If they had a good experience in the healthcare environment, they were more adept to continue healthcare treatment and build a relationship with their healthcare professional.	Sophie: You know, my doctor knows- she's- she's my-my advocate. She's my- I feel very supported by her and by the doctors office, um. I mean I actually enjoy going to the doctor's office.
Bad Experiences	In other cases, a bad experience ruined a participant's healthcare involvement. Some participants navigated the communication interaction with fear of discrimination, ultimately, avoiding healthcare altogether, like Kevin.	Kevin: To where its like I'm obviously this like, Jerry Springer sort of um, token and its-its- he's cool and shit, but I mean, it makes me feel like- like a freak show, like a circus freak show oddity. And um, and so I'm afraid to go to doctors.
Advice (Personal Behavior)	Each participant expressed the ways in which they navigated the healthcare interaction. However, some participants gave advice to doctors on how THEY could navigate the healthcare interaction. One of the recommendations was to change or alter personal behavior to improve the interaction.	Jaston: Stay in line with the pronouns that I prefer…treat me like a normal human being. Get to the point and don't try to prescribe me anything that I don't need.
Advice (Office Logistics)	Another kind of advice to doctors from participants involved the office logistics such as including trans as a gender marker option on intake forms and updating office websites to clearly state a support and treatment	Meli: At the medical community and that's something I told my physician, that she should do is- is to have that as something as an option on the intake forms.

	for LGBT individuals.	

APPENDIX E

RESEARCH QUESTION TWO THEME ANSWERS

RQ2: How do transgender individuals employ co-cultural strategies and communication approaches with healthcare professionals in the doctor's office?

THEME	HOW IT ANSWERS	EXEMPLAR
Emphasizing Commonalities	Many participants purposefully sought out doctors that they felt comfortable with based on the things they had in common. For some this meant having a doctor that also identified as trans, or some facet of the LGBT community. Participants used this strategy to locate or become comfortable with their healthcare professional.	Meli: I was searching for gender therapist. This was one therapist who identified as being transgender…. I thought you know, who else better to understand my situation than um, somebody who was also transgender… I think that knowing that this doctor, the doctor that deals with somebody that specializes with those that are transgender makes it so much easier for someone that is to have easy communication-have easy communication with them.
Communicating Self	Several participants demonstrated a level of confidence that allowed them to "communicate self" to their doctors. Participants utilized this strategy to help achieve their goals in the healthcare environment and stand their ground as a stable human being, a trans one at that.	Harold: I can speak about my body and its parts without feeling triggered. And so, I think that like, my patient care changes as I come-I come in confident, and ready- and ready to speak about my problems in a space where- that I don't feel as vulnerable.
Rationalization	Participants used rationalization to give excuses as to why their doctors behaved in the ways they did. The excuses ranged from the doctor having a bad day, to trans individuals just being hard to work with, to the	Conner: I did go to that- a different doctor recently for my back and I don't know if he just wasn't having a good day, but or he realized I was trans. But he was kind of short with me. So I don't really know what the situation was. If it was just-

	medical staff just being ignorant.	it was the end of the day and he wanted out of there or he realized I was trans and didn't really want to deal with me.
Maintaining Barriers	Participants primarily used this strategy when confronted with a bad experience. Many participants described situations where they were verbal about their feelings and opinions, whereas others, like Larry, simply got up and left the situation.	Larry: I was just miserable. I was super uncomfortable and so I just was like, you know what, if they're not gonna treat me right and I'm not dying, I'm going home. (laughs) so I did.
Educating Others	The majority of participants felt as though they needed to educate their doctors to some degree. Participants used this strategy to either help their own healthcare treatment or improve the doctor's level of knowledge.	Ariel: Generally everyone (pause) doesn't treat me poorly. It's just annoying that I usually know more than them. I have to educate them.
Incompetent Doctors	The unfortunate reality discovered in the data is that most doctors just do not have enough education, nor wish to gain the knowledge necessary, to treat trans individuals. When faced with an incompetent doctor, some participants felt compelled to educate them while others would get frustrated and leave the situation feeling offended and with a lack of confidence in healthcare professionals as a whole.	Brandon: I didn't wanna be with somebody who didn't understand or didn't seem to have the care and capacity for dealing with a transgender person. And I mean, he- he told me in his own words that he didn't know anything about this and didn't want to learn. And so I didn't- I didn't wanna be with that anymore.

APPENDIX F

THEME AND SUBTHEME ONE SENTENCE DEFINITIONS

THEME/SUBTHEME	ONE-SENTENCE DEFINITION
The Concept of Passing	"Passing" signifies a person who can present as being a particular gender without the "original" sex being suspected (Namaste, 2000).
Overall Healthcare Goals	The desire to be treated with respect, to be treated for whichever ailment is present, and leave with answered questions when visiting the doctor.
Overall Healthcare Goals (Helped)	Distinctive situations or people that facilitated the attainment of a participant's overall healthcare goals.
Overall Healthcare Goals (Hindered)	Particular things or feelings that prevented participant's overall healthcare goals from being achieved.
Location Matters (Advantage)	Participants experiencing positive healthcare situations and receiving more access to healthcare opportunities in regards to their location within the United States.
Location Matters (Disadvantage)	Participants noticing the downfalls of the location or region they resided in related to the opportunities available in proper healthcare.
Good Experiences	Those experiences that involve a doctor leaving their trans patient feeling like they are cared for in terms of their physical, mental, and emotional health.
Bad Experiences	Those experiences that involve a doctor that leaves a trans patient feeling distressed, uncared for, and as though they are not authentic.
Advice for Doctors (Personal Behavior)	Participants describing ways in which their doctors and office staff could change their behavior to make the health environment easier to enter.
Advice for Doctors (Office Logistics)	Participants explained ways the office organization could be changed to make the initial contact with the office easier for trans individuals.
Co-Cultural Strategies	The use of different approaches to potentially stressful conversations by non-dominant cultures when communicating with dominant cultures.
Emphasizing Commonalities	Occurs as participants express feeling more comfortable with doctors who had similar qualities making communication about their healthcare easier.
Communicating Self	Occurs as participants report feeling comfortable and confidant to discuss their trans identity with their doctor without fear of discrimination or rejection.
Rationalization	When participants speculate as to why their doctor was uneducated on trans issues, treated them badly, or did

	not feel comfortable treating trans individuals.
Maintaining Barriers	Participants feeling the need to back away from a situation and build a psychological blockade, verbally or nonverbally, to all communication with their doctor.
Educating Others	Participants feeling the need to teach, or inform, their doctors on trans-related information, medically, socially, or in the general sense of what it means to be transgender.
Incompetent Doctors	Participants noticing their doctor's inability to learn when it comes to the general knowledge of trans issues and how to medically care for trans individuals, ultimately deeming the doctors as useless.