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GETTING BY GATEKEEPERS:

TRANSMEN'S DIALECTICAL NEGOTIATIONS

WITHIN PSYCHOMEDICAL INSTITUTIONS

by

Elroi L. Waszkiewicz

Under the Direction of Dr. Mindy Stombler

ABSTRACT

Transsexuality remains grounded in pathologizing discourses. Mental health professionals largely classify transgender experiences as disorders, and transgender people seeking to alter their bodies typically must obtain authenticating letters from therapists verifying such diagnoses. Physicians usually require these letters to perform transition-related services, and sometimes require additional legitimization. In these ways, psychomedical professionals impose gatekeeping measures that withhold and confer services to transsexuals who desire medical transition. Using qualitative interview data and grounded theory methods with 20 female-to-male transsexuals, this study demonstrates that transmen typically represent informed consumers whom carefully research psychomedical protocol and anticipate providers' adherence to professional standards. When they encounter gatekeeping, this preparedness informs their dialectical struggles within the psychomedical institutions wherein transmen must negotiate bodies within the confines of pathology.

Ultimately, this dialectical process is managed and maintained by the larger regime of truth—the gender binary system.

INDEX WORDS: Transsexualism, Transsexuals, Transsexual men, Female-to-male transsexual, FTM, Transmen, Transgender, Psychomedical institutions, Pathologizing discourse, Grounded theory methods, Medical gatekeeping, Gender identity disorder, Gender dysphoria

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by

ELROI L. WASZKIEWICZ

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

2006

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2006

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by

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Dedication

This thesis is dedicated to all of the people who participated in this study. For the men, transmen, transmales, FTMs, intersexed, gender fluid, and genderqueer people in this project, I extend my sincerest gratitude to your contributions. May this study aid in creating a safer place for all transgender people to access and receive quality health care.

Acknowledgements

In creating this thesis, a laborious love, I owe thanks to many people. First and foremost, I thank everyone who participated in this project. Your willingness to share your experiences provided the basis for everything herein. I take full responsibility for this end product, but could not have arrived here without your thoughtful contributions. In addition, I am thankful that part of this research was supported by a grant from the Transgender Scholarship and Education Fund of the International Foundation for Gender Education. I am also grateful for travels grants provided by Georgia State University's Sociology department that supported preliminary presentations of findings within academic and community forums.

I have been fortunate enough to have worked with talented and committed sociologists. Most notably, the faculty that have worked in the Department of Sociology at Georgia State University provided me with endless support and encouragement. My officemates and fellow graduate students also provided intellectual and comical relief. Of all these marvelous sociologists, my deepest gratitude goes to my committee members. Thank you Elisabeth Burgess and Wendy Simonds for your insights and support. And most of all, my most heartfelt thanks and appreciation is reserved for my committee chair, Mindy Stombler. With your constant dedication and inspiring visions, I felt confident in growing as an academic under your guidance. I truly value your commitment to my work and progress, and could not have asked for a more excellent mentor. Thank you for believing in me.

And finally, for all of the behind-the-scenes support, understanding, and consolation, I extend warmest thanks to my love, Alyson Stealey. You're the best!

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List of Abbreviations

APA	American Psychiatric Association
DSM-IV-TR	*Diagnostic and Statistical Manual, Fourth Edition, Text Revision*
FTM	Female-to-Male Transsexual
GID	Gender Identity Disorder
HBIGDA	Harry Benjamin International Gender Dysphoria Association
ICD-10	*International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Second Edition*
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning
MTF	Male-to-Female Transsexual
SOC	*Standards of Care*
SRS	Sexual Reassignment Surgery
T	Testosterone
Trans	Transgender

Introduction

Years ago, I heard the alarming horror stories experienced firsthand by the transgender people I met while working as a health educator in an AIDS task force. I learned about countless injustices endured by transgender people, especially in health care settings. In addition, my decade-long involvement with the LGBTQ community afforded me the opportunity to meet and befriend many transgender people. While living in New York City, I was very active within feminist and queer activist communities. I met many transsexual men in these contexts, and it appeared that female-to-male transsexual men occasionally utilized these presumed supportive spaces to come out as transsexual. These acquaintances gave me further insight into the discontent surrounding health care for transgender people.

Consequently, my professional and personal background fostered my interest in conducting research that would benefit the transgender community. And over time, I have established myself as an ally to and member of the transgender community. As a genderqueer person, I have grown to identify with the transgender community through my own lifetime experiences with gender identity and expression. As a researcher, I believe this membership granted me access to the transmen's community as somewhat of an insider. Transmen often perceived me as someone that could relate to their experiences to some degree. They also understood that I supported their individual subjectivities without making them defend their identities and decisions. But because I am not a transsexual and do not identify as a

man, I was also an outsider to this community. While my outwardly masculine appearance and gender expression sometimes inspire people to perceive me as a burgeoning transsexual, I am comfortable inhabiting a body unaltered by hormones and surgery. In this way, I had no personal experience navigating the transsexual-specific health care services that all of my respondents procured. Thus, my simultaneous insider/outsider researcher relationship to this community afforded me the ability to access information that was sometimes very sensitive and private while maintaining a less informed perspective on the health care experiences I sought to understand.

At the start of this project, I believed that my research inquiry would expose an array of inequalities that transmen experienced in accessing and receiving health care. As a marginalized population, I expected that transmen would encounter discrimination in their interactions with providers. Indeed, many transmen in my research sample reported such instances. However, others navigated health care without many problems at all. Using grounded theory methods, I was able to discern that a key factor that informed health care interactions was the prevalence of psychomedical gatekeeping, or the process of validation, authorization, and legitimization wherein health professionals confer or withhold transition-related services. In some cases, gatekeeping represented a barrier to care, and thus exposed discriminatory episodes that I expected to encounter. But for other transmen, gatekeeping aided them in their pursuit of appropriately gendered bodies. By interpreting the data within a poststructural theoretical construct, I was able to

pinpoint how a pathologizing discourse imposed normative narratives on transsexual subjectivity and thus framed transmen's abilities to negotiate medical transition.

The resulting thesis has been divided into six sections. Following this introduction is a review of the relevant literature. In Chapter 2, I relay the methodological choices employed in this research and justify their use in exploring transmen's experiences within health care systems. Chapter 3, "Becoming Informed Consumers," represents the first chapter of research findings, and details the process of transmen learning about medical transition and what they can expect in navigating health care systems. Chapter 4, "Psychomedical Gatekeeping," chronicles actual instances of providers imposing or conferring transition-related services based on a variety of important social factors and contexts. In Chapter 5, "Negotiating Bodies within the Confines of Pathology," I discuss how transmen negotiate medical transition while enduring management by psychomedical institutions. Chapters 3, 4, and 5 each begin with eloquent quotations from transmen that illustrate the central tenet of each research finding. And finally, Chapter 6 offers a brief discussion and conclusion to these research findings. Before further outlining these accounts, it is necessary to explain some concepts used in this study.

Explanation of Concepts

For clarification purposes, I provide the following terms to familiarize readers with language used throughout the project. Female-to-male transsexuals (FTMs) are people who were assigned a female gender or sex at birth based on biological anatomy who have chosen or plan to physically alter their bodies through the use of

hormones and/or surgery to emphasize the male gender. FTMs may also identify as male, man, transman, transmale, new man, man of transgendered experience, intersexed, trannyboi, boi, genderqueer, third- or bi-gendered, and/or other identities that represent culturally defined masculine gender characteristics, and may identify as FTM without desiring hormones or surgery. However, this study focuses on people who identify as transmen or FTM and have taken steps to physically alter their bodies through hormone therapy and/or surgical procedures. I refer to the process of accessing hormones and surgery as medical transition. Some transgender people contest the word "transition," asserting that they are not "transitioning" because they have always been the gender that they express. I recognize this gesture and only employ the term in reference to the transition of the body. Through hormones and surgery, the body does change, or transition, from one form to another. These changes are gendered. But by using "medical transition" instead of "gender transition" or "sex change," I situate transsexuals' changes in the body. In addition, I use the term "transgender" as an umbrella term that represents a variety of gender transgressions. The word "transman" is synonymous with FTM or transsexual man. The LGBTQ vernacular commonly includes the words "trans" and "trans people" as synonymous with "transgender." Such terms will be used throughout this thesis.

I also wish to address a few common misperceptions about transmen. Some people believe transmen all share histories of identifying as butch lesbians and select women for sexual partnering. Transmen, like a person of any other gender, may identify as gay, straight, bisexual, queer, or any other sexual identity. Transmen's gender identities are conceptually different from their sexual identities. Furthermore,

it is important to avoid assuming that any person's sexual identity matches that person's sexual partnering choices. Meaning, a person may identify as heterosexual, but have had same-sex sexual experiences. Such incongruencies occur in all genders and are not unique to transsexual men. Finally, many transsexual men get chest reconstructive surgeries as the only transition-related surgery, and thus do not pursue genital surgeries for a variety of reasons, including inadequate technology, financial barriers, and health risks. Thus, the popular culture terminology of getting "a sex change" is a bit misleading concerning transsexual men's medical transitions.

Chapter 1: Literature Review

Transgender people encounter inequality, discrimination, and bias within health care systems. They have consistently reported negative experiences and overt discrimination in both accessing and receiving health care (Bockting et al. 2004; LGBT Health Channel 2002; Lombardi 2001; Lombardi and van Servellen 2000). Many transgender people fear seeking health care due to the horror stories of mistreatment that circulate throughout the trans community (Feinberg 2001; Lombardi 2001). Others cannot access care due to economic barriers (Kammerer, Mason, and Connors 1999). Job instability and lack of health insurance present transsexuals with additional financial burdens (Feinberg 2001; McGowan 1999). Nearly all public and private health insurance companies do not cover transition-related care, regardless of any health risks involved (Goodrum 1998; Hong 2002; Lombardi 2001). The Health Care Finance Administration's classification of sexual reassignment surgery[1] (SRS) as experimental largely informs insurers' decisions to exclude coverage related to medical transition (National Coalition for LGBT Health 2004). Additionally, insurers may also penalize transgender people by refusing to cover services unrelated to gender (Green 2000; Hong 2002). While more trans-friendly services exist presently, many trans people living in isolated or rural areas lack access to these specialists (Lombardi 2001). Even health care services designed by and for the LGBTQ community may lack genuine transgender sensitivity (McGowan 1999), especially when dealing with transgender youth (Davis 2002). These factors prevent many transgender people from accessing health care. But even

[1] I employ the term "sexual reassignment surgery" only when it exists in the literature. I appreciate the transgender community's critical analyses of this terminology as inaccurate, and prefer to use more affirming terms when appropriate, such as sexual realignment surgery or gender-affirming surgery.

those that successfully access care may experience discrimination in receiving services.

Trans people encounter difficulties during interactions with providers, often due to social stigma (Kammerer et al. 1999). Violence against transgender people is common, and transgender status can affect sensitive delivery of health care services (Witten 2003). Transsexuals often face discrimination in receiving general medical care, mental health care, hormone therapy, and surgical procedures (LGBT Health Channel 2002). Intake forms used by health care systems force trans people to categorize their names and genders in limited terms that may not capture their health care needs and identity preferences (Miller and Weingarten 2005). Advocates within the trans community urge health care professionals to become more educated about transgender issues and lives (Bockting and Robinson 1998), an effort that has a lengthy history (Meyerowitz 2002).

As a result of the problems transgender people encounter within health care, advocates for transgender people have stressed the importance of studying their experiences in these systems (Lombardi 2001; Lombardi and van Servellen 2000; Hong 2002). Many researchers have answered this call with increased interest in studying the health care needs of transgender people. While interest in research on FTM communities is growing, few social researchers focus exclusively on transmen.[2] And scholars that study transgender health care issues typically neglect to thoroughly examine the interactive process of pursuing medical transition for transmen and their providers. Trans people who seek medical transition must obtain approval from the health care systems that treat them (Green 2000). My research attempts to address

[2] For important exceptions, see Cromwell (1999), Devor (1997), Rubin (2003), and Schilt (2006).

this under-researched area, focusing on the phenomenon of psychomedical gatekeeping, or the process of validation, authorization, and legitimization wherein health professionals confer or withhold transition-related services. This phenomenon stems from a long tradition of pathologization that transsexuals have endured since they were allowed the opportunity to pursue medical transition. This history frames the ways psychomedical institutions manage transsexual pursuits of differently gendered bodies.

A History of Disorder

Scholars have documented gender-bending behaviors and practices throughout history and across cultures (Feinberg 1996; Lev 2004). Although gender diversity preceded clinical classification for centuries, the medicalization of transsexuality can be traced to around 1910 when sexologist Magnus Hirschfeld first used the term “transvestite” in print (King 1933). The early twentieth century represented an exciting time for pioneering sexologists and sex researchers, who began to examine the phenomena of cross-dressing and homosexuality within clinical frameworks (King 1993). The first attempt at surgically creating a vagina for women occurred in 1761, but effective methods of creating vaginas blossomed in the 1930s (King 1993). At this time, hormones and surgeries became available for changing sex (King 1993). Psychiatrists became more intrigued with the different forms of gender-crossing behavior as the latest perversion by World War II, even though they lacked many real-life, actual documented cases of the behavior (King 1993).

While psychiatrists, endocrinologists, and surgeons may not have known exactly what they were doing with their prescribed procedures, the ability to change sex became established as a possibility by 1950 (King 1993). At this time, medical communities began to construct the boundaries of the category of transsexual (King 1993). Psychological explanations soon increased in popularity, and classifications of transsexuals, people who wanted to change their bodies, became distinguished from transvestites, or those who occasionally cross-dressed for sexual gratification (King 1993). They theorized about foundations for this condition, and recommended innovative and controversial techniques for treating it (King 1993). Medical practitioners subscribed to theories of intersexuality in patients seeking sex changes, and rooted their problems in biological explanations (King 1993). These providers were not well respected by their colleagues, so they began to formalize treatment protocol to legitimize their actions (King 1993). Hormonal and surgical procedures were used to "[restore] a natural harmony between the various (physical and psychical) sexual characteristics" (King 1993:90). Meaning, health professionals sought to maintain binary gender, aligning the body (sex) with the mind (gender/gender identity) (King 1993).[3]

In the 1960s, transsexuals garnered increased attention from psychomedical professionals that debated appropriate treatments (Shapiro 1991). Gender clinics emerged to research the occurrence of transsexuality and to correct it (Stone 1991). Early pioneers like Harry Benjamin, John Money, Robert Stoller, and Richard Green encouraged providing transsexuals with opportunities for hormonal and surgical procedures to satisfy their gendered desires (Shapiro 1991). These men were

[3] For a more detailed history of the medicalization of transsexuality, see King (1993).

primarily clinicians and researchers that held conventional attitudes about gender (Shapiro 1991). Literature published through the mid- to late-1960s stressed the immutability of gender (King 1993). Thus, justifying sex-changing procedures biologically made sense: it was important to align bodies with the mind, which could not change gender (King 1993). Hereafter, psychotherapy became increasingly important to sort out potential candidates for medical intervention, thus sanctioning therapists' roles as gatekeepers (King 1993).

In 1973, the term "Gender Dysphoria" surfaced to identify people that felt intense discomfort with their gender identities and biological sex (King 1993). Gender Dysphoria eventually became the primary diagnosis for those seeking medical intervention. Based on emergent clinical research in this area, the *Diagnostic and Statistical Manual* (DSM) of the American Psychiatric Association established the term "Transsexualism" under the broader category of "Gender Identity Disorders" in 1980 (King 1993). This classification represented the premiere of "Transsexualism" as an official disorder (Stone 1991).

Even after the emergence of "Transsexualism" under "Gender Identity Disorders," gender clinicians continued to prefer the term "Gender Dysphoria" because it emphasized gender concepts over biology and the condition over the person (King 1993). Professionals gained authority for treating the condition, and the term legitimized all those who suffered from gender dysphoria, not just transsexuals (King 1993). Referring to people as having the condition of Gender Dysphoria instead of inhabiting the identity of "transsexual" remedied problems doctors had in diagnosing and treating potential transsexuals, and broadened their market to include

a range of clients who suffered any degree of gender distress (Billings and Urban 1982). Most importantly, this classification legitimized sex change procedures by separating the diagnosis from the treatment, minimizing impulses to treat "transsexuality" with sex change (King 1993).

Clinicians developed criteria for gender dysphoria to justify surgical procedures, profiting from emergent funding opportunities (Stone 1991) in the early 1980s. The Harry Benjamin International Gender Dysphoria Association issued the first edition of *The Standards of Care for Gender Identity Disorders* in 1979, followed by revised editions in 1980, 1981, 1990, 1998, and 2001 (Meyer et al. 2001). Clients' satisfaction with surgery outcomes further legitimized the procedure (Billings and Urban 1982). Physicians advocated for transsexual surgery to justify their own roles as healers, advocate for innovative psychiatric research and plastic surgery procedures, and garner more clients in the competitive, capitalistic health care market (Billings and Urban 1982).

The shift in classification also generated more respect for therapists treating gender dysphoria, even though the surgeons and endocrinologists remained fairly marginalized within their profession (Bolin 1988). In her study on male-to-female transsexuals (MTFs), Bolin (1988) quoted one "sensitive" psychiatrist and "advocate of transsexuals" as saying:

> Although consumers don't like the DSM-III classification…it has legitimized gender dysphoria…in that it is now a legitimate psychiatric diagnosis. While the surgeons of gender dysphoria are feeling out of mainstream medicine..., the psychiatrists have been getting more acceptance now that they are validated by the DSM-III. (P. 54)

Through legitimizing gender dysphoria as a viable disorder, "psychiatrists have enhanced their own credibility at the expense of stigmatizing their clients as mentally ill" (Bolin 1988:54). Patients seeking medical transition thus had to endure therapy and live in their chosen genders successfully prior to medical intervention (Billings and Urban 1982). In 1994, the DSM-IV replaced "Transsexualism" with "Gender Identity Disorder" (Meyer et al. 2001) as the primary classifications that still exist today. Gender Identity Disorder (GID) prevails as the "official diagnosis for transsexualism" and is the preferred terminology employed within the DSM (Lev 2004:148). While transgender people and their health care providers may conceive of the term "dysphoria" more as discomfort than mental illness (Devor 1996), its clinical use remains grounded in pathologizing discourse. Inevitably, however, "[t]he diagnostic label of GID is the official proof that one is a transsexual and therefore eligible for medical assistance" (Lev 2004:177).

This history of disorder frames present-day medicalization of transgender subjectivities. Treating transsexual procedures as rooted in pathological desires informed and continues to influence how psychomedical institutions clinically manage medical transition. However, health care professionals have not monopolized the discourse on appropriate managements of transsexual bodies.

More Problems with Transsexuals

Sociocultural literature primarily from the disciplines of sociology[4] and anthropology expanded clinical understandings of transsexuality (Bolin 1988). While

[4] For examples of sociological examinations in ethnomethodological and symbolic interactionist traditions, see Garfinkel (1967), Kando (1973), Feinbloom (1976), and Kessler and McKenna (1978).

clinical approaches to studying gender focused on etiology and treatment, sociocultural approaches attempted to understand transsexuals in relation to society (Bolin 1988). Scholarly work on transsexual experiences commonly aimed to understand and explain the development of atypical gendered paths[5] (Ekins 1997). While disinterested in treating transsexuals, these researchers primarily viewed transsexuality as somewhat of an oddity that could help illuminate more conventional notions of gender.

Feminist critics offered more opinioned perspectives. In the late 1970s, feminist theorists problematized transsexuality and critiqued medical establishments for doctoring gender and sexuality to further oppress women[6] (Bolin 1988; Ekins 1997). For example, Raymond (1979) argued that by pursuing medical transition, transsexuals objectified the female form and thereby raped women's bodies. These feminist arguments sparked controversy and discussion, but lacked sufficient empirical basis for understanding the medicalization of transsexuality. Marxist sociologists Billings and Urban (1982) expanded on feminist critiques of transsexuality, arguing that transsexuals represented a socially constructed reality enabled and created only by psychomedical institutions. They criticized medicine for praising surgically constructed genitals as luxurious commodities for "sexual deviants" and "victims of aberrant gender-role conditioning" (Billings and Urban 1982:107). They questioned transsexuals' reports of surgical satisfaction, arguing

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[5] For examples, see such historical texts as Benjamin (1966), Green (1974; 1987), Money and Ehrhardt (1972), and Stoller (1968).

[6] For an excellent overview of the historical theoretical debates between feminist theory and transgender subjectivity, see the "Feminist Investments" and "Queering Gender" sections of Stryker and Whittle (2006). For contemporary feminist critiques of transsexuality, see Raymond (1979), Jeffreys (2003).

that the permanence of genital surgery demanded that patients invent new ways to deal with their irreversible decisions (Billings and Urban 1982). While Billings and Urban (1982) argue that the medical discourse of transsexuality supports conventional gender systems, they faulted transsexuals for accepting bodily mutilation over resisting gender stereotypes. These perspectives neglected to critically evaluate the social process of medicalization as experienced by transsexual people and their autonomous decisions to pursue differently gendered bodies. As one prominent transsexual man explained:

> When we focus on the proposition that dichotomous gender is the bellwether of social privilege, and when we view transsexual people as social constructions of social constructions in an attempt to understand how gender conventions are learned or manipulated, we actually deny the incredible potential of gender variance and its natural diversity, and we categorically deny both transindividuals and non-transindividuals agency in experiencing or freely expressing their own genders" (Green 2005:294-5).

In other words, it is unfair and myopic to demand that transsexual subjectivity deconstruct binary gender any more than non-transsexual subjectivity. Doing so affords non-transgender subjects the privilege to assume stable gender statuses without the critical attention that all genders might endure in cultures that regard gender diversity with suspicion.

Perpetuating the Typical True Transsexual Narrative

The discourses produced within medical and academic arenas did not go unnoticed. While doctors, psychiatrists, and social theorists debated ways to deal with transsexuals, transsexuals were listening and devising their own responses to the psychomedical discourse. When doctors discussed bringing the body in line with the

mind during the 1960s, they also introduced the metaphor of being born in the wrong body into popular culture (Meyerowitz 2002). Transsexuals asserted the existence of a true or inner self that needed to be freed (Meyerowitz 2002), a decidedly essentialist notion (Queen and Schimel 1997). Thus, the narrative of being born into or trapped in the wrong body became widespread and well known among transsexuals who could produce this history on demand (Meyerowitz 2002).

Though predated by transsexual autobiographies, Benjamin's publication of *The Transsexual Phenomenon* in 1966 guided researchers in classifying transsexualism (Stone 1991). After several years of treating transsexuals who beautifully matched the profile, these researchers realized that their clients had also read Benjamin's book and had mimicked the behaviors needed to gain access to medical transition (Stone 1991). By the early 1970s, practitioners knew that many transsexual patients were well acquainted with the etiological literature and lied to get surgery (Billings and Urban 1982). Their transsexual patients produced carefully crafted narratives, leaving out unacceptable histories like drug abuse or criminal acts and emphasizing gender stereotypes (Billings and Urban 1982). Transsexuals also learned through attending transgender support groups what biographical information to emphasize, and what to disguise, in order to present appropriately gendered narratives (Mason-Schrock 1996).

While scholars revealed that transsexuals studied medical literature to carefully construct narratives to aid medical transition (Billings and Urban 1982; Feinbloom 1976; Kando 1973; Meyerowitz 2002), they failed to address the reasons why transsexuals needed to invoke such particular narratives. Researchers and

transsexuals had starkly different goals in treatment. Researchers wanted to define and explain gender dysphoria, and transsexuals wanted surgery—a desire that motivated their relationships to these researchers (Stone 1991). Transsexuals constructed these narratives in order to be granted the bodies they desired within the confines of the pathological discourse of psychomedical institutions. Transsexuals did not simply lie for surgery, but they had to offer specific narratives in order to qualify for surgery. If their stories differed from the typical narrative, they risked being denied the ability to change their bodies. So transsexuals presented a neat and consistent history so that they could access hormones and surgery.

Bolin (1988) documented how information about the typical narrative spread within the transsexual community. Through interactions with others, the transsexual community produced an extensive "transsexual lore" on manipulating and capitalizing on caretaker's stereotypes about transsexuals (Bolin 1988:64). Transsexuals knew what to hide and reveal to avoid risking dismissal by caretakers and present an identity that conformed to stereotypes (Bolin 1988). Bolin (1988) expressed disappointment that transsexuals further confirmed caretakers' stereotypes about transsexuals, but neglected to critically evaluate the institutional paradigm that mandated these narratives. Instead, she noted that by learning to be dishonest, transsexuals were less likely to receive positive and productive therapy in guiding the major life decision of changing sex (Bolin 1988). Bolin (1988) concluded that transsexuals' "only recourse is one in which they contribute to the perpetuation of stereotypes and generalizations and thereby foster impressions of a homogenous population. This leads to a self-fulfilling prophecy and promotes a situation in which

both caretakers and clients suffer" (p. 65). However, the conclusion that transsexuals aid in the maintenance of pathologizing diagnostic criteria is overly simplistic, as transsexuals in my study used these narratives in a more dialectical fashion.

The Effect of Pathology on Transsexual Experiences in Health Care

The history of disorder and transsexuals' negotiations of clinical diagnoses has affected the ways transsexuals interact within the health care professionals of psychomedical institutions. Today, most health care professionals who authorize transition-related treatment for transsexuals rely on the guidelines outlined in *The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders* (HBIGDA SOC). The *Standards of Care* guide mental and general health care providers in treating transgender clients and determine eligibility for medically regulated transition (Meyer et al. 2001). These standards of care set parameters for the recommended care and treatment for people that mental health professionals deem to have some form of Gender Identity Disorder (GID) (Meyer et al. 2001). It is within the parameters of this confining discourse that many providers deliver services to transgender people and thus serves as the basis for psychomedical gatekeeping.

Psychomedical gatekeeping represents an under-researched area of transgender experiences within health care. One clinical study attempted to examine transgender people's attitudes towards gatekeeping in relation to overall satisfaction with health care. In a clinical study of their transgender and nontransgender mental health clients, Bockting et al. (2004) assessed client satisfaction with both medical

and mental health services. Unfortunately, the questionnaire did not specifically measure attitudes about or satisfaction with psychomedical gatekeeping. However, open-ended responses on their survey instrument revealed a theme concerning client dissatisfaction about gatekeeping (Bockting et al. 2004). These data exposed a measurement oversight and prompted the researchers to suggest further research in this area.

Most research that addresses gatekeeping limits the focus to therapy interactions. Rachlin's (2002) study included attitudinal measurements about gatekeeping within transgender mental health care contexts. Acknowledging dilemmas that the gatekeeping role introduces into the therapy-client interaction, Rachlin (2002) studied the reasons why trans people entered into psychotherapy and asked respondents to rate their outcomes. The few people who sought counseling solely to obtain a legitimizing therapist letter generally expressed satisfaction with the experience and spent lower lengths of time in therapy than those who attended for other reasons (Rachlin 2002). Others who sought letters among other reasons for accessing therapy also benefited from more comprehensive mental health care (Rachlin 2002). These findings suggest that Rachlin's transgender clients did not feel hindered by gatekeeping. But while her analysis examined those respondents who reported accessing therapy in order to obtain a therapist letter to authorize medical transition, the survey instrument did not directly inquire about gatekeeping. For example, Rachlin (2002) did not report asking respondents whether they felt hindered by therapists' demands, expected to produce typical transsexual narratives, or other aspects of gatekeeping that my study identified as affecting transmen's experiences

within health care systems. Rachlin's (2002) study also contained several other important limitations. Her sample size was limited to 93 participants, most of whom were FTMs in attendance at a transgender conference. Thus, the sampling was not random, but convenient, thereby limiting the interpretation of its correlational statistical data. The study then offered only a brief snapshot of transgender experiences with gatekeeping.

Perhaps the most informative study on gatekeeping gauged transgender people's familiarity with the SOC, whether they followed them, and what their opinions on the SOC were (Denny and Roberts 1997). Based on survey responses, Denny and Roberts (1997) found that about 79% of respondents had heard of the SOC, mostly from professional and transgender contacts. About 83% of respondents had engaged in therapy to deal with gender issues, and about 44% knew about the SOC prior to their first therapy encounters. Concerning respondents' opinions about the SOC, the majority valued therapist evaluations and authorizing letters, supported one-year minimums of living in the desired gender prior to SRS, and believed the SOC were useful (Denny and Roberts 1997). These positive opinions of suggestions outlined in an earlier edition of the SOC ranged in support from 72-88% among all respondents, and from 77-95.2% among respondents with previous knowledge of the SOC (Denny and Roberts 1997). Respondents were least supportive of the SOC requiring therapist letters for FTM chest surgery and commitment to genital surgery prior to receiving hormones (Denny and Roberts 1997). Additionally, written comments suggested that respondents viewed the SOC as needing changes, especially

regarding their flexibility (Denny and Roberts 1997). Denny and Roberts (1997) conclude that most people affected by the SOC actually support their use.

However, this study suffers from serious limitations. First, the authors believe that the SOC have generally served the transgender community well and conducted the study mainly because they were incredulous about "supposed widespread dissatisfaction" with the SOC (Denny and Roberts 1997:323). This bias likely informed their decision to dichotomize survey answers into simple "yes" or "no" replies to six questions, instead of capturing more gradated responses. Next, while they received an impressive amount of surveys from 349 respondents, the sample overrepresented the viewpoints of MTFs, who represented 79.6% of the sample. The authors dismissed any differences that might exist between these populations by electing to provide only descriptive percentages that underwent no statistical analyses. As such, the significance of these figures remains unknown and is a major weakness of the study.

All of these studies that attempted to study gatekeeping lacked thorough exploration of the gatekeeping process within psychomedical institutions. Aside from anecdotal evidence, limited statistical data, and clinicians surveying their own clients, researchers do not know much about transgender people's experiences with gatekeeping. While some health professionals' research remains critical of the ways psychomedical institutions pathologize transsexuality and regulate gender authentication, interested parties should warily interpret their research findings. Transgender people must rely on therapists and doctors to assist their transitions. Health professionals possess an obvious stake in evaluating transgender people's

health care satisfaction and experiences with gatekeeping. Conversely, trans people rely on the services offered by the psychomedical institutions studying them, and thus have an interest in presenting higher satisfaction with their services (Bockting et al. 2004). Therefore, studies on gatekeeping designed by gatekeepers warrant some caution. Scholars need to more closely examine trans people's experiences with negotiating the SOC (Bockting et al. 2004).

In her anthropological study on MTFs, Bolin (1988) argued that while the SOC are beneficial in averting unwanted and irreversible surgeries, they inherently and inevitably represent:

> an inequity in power relations such that the recommendation for surgery is completely dependent on the caretaker's evaluation. This results in a situation in which the psychological evaluation may be, and often is, wielded like a club over the head of the transsexual who so desperately wants the surgery. (P. 51)

Bolin (1988) found feelings of hostility toward health care professionals among her sample of MTFs. She quoted one transwoman who explained a lifelong process of having her identity invalidated by therapists that "are more interested in protecting their malpractice insurance than your well being.... [A]t no point are the transsexual's feelings acknowledged as legitimate and deserving of action. How else could we feel but hostile?" (Bolin 1988:52). When the SOC bases its reasoning on a mental illness model, transsexuals must succumb to therapists' evaluations and diagnoses to gain legitimization (Bolin 1988). Of course, not all transsexuals report negative experiences in therapy.

The prevalence of psychomedical gatekeeping does not always hamper transsexuals' experiences in health care. Undoubtedly, therapy can be beneficial for

many people for myriad reasons. Transgender people often report positive experiences with psychotherapy (Rachlin 2002). In one study, transgender respondents highly rated positive aspects of therapeutic relationships, such as therapists' acceptance and clients' ability to openly communicate (Bockting et al. 2004). Negative therapy experiences often result from providers lacking experience with transgender clients (Rachlin 2002).

But the SOC that recommend therapist approval prior to medical transition still present an additional barrier to transgender health care. Many trans people view psychotherapists as gatekeepers who decide their eligibility for medical transition (Bockting et al. 2004). Strained relationships have historically characterized the interactions between transgender people and their doctors (Meyerowitz 2002). Therapists believe that when transgender clients enter therapists' offices prepared to present credible stories based on what they learned from other transgender people and from psychomedical literature, such informed perspectives present problems in accurately referring clients for surgery (Bower 2001). To combat these issues, therapists have proposed new models for working with transgender clients.

Emergence of New Therapy Models

Due to considerable social and political pressure from transgender communities, psychotherapists have started embracing more affirmative trans-positive models in working with trans clients (Raj 2002). Many providers with interests in embracing trans-positive health care models have become overwhelmed with models that conceptualize gender as anything other than a binary or continuum

from going to one point to another (Singer 2006). Subsequent uncertainty with non-linear and multidimensional transgender terminology may inspire providers to return to simpler models. Indeed, complex gender theories and models that incorporate transgender experiences can confuse those with sincere desires to understand. But some have recognized gatekeeping as a potential barrier to care that presents a challenge for both providers and their clients and work to eliminate "clinical transphobia" during therapeutic encounters (Raj 2002:3).

One prominent example of new therapy models was published in an extensive clinical guidebook. Lev (2004) based her transgender-affirming model on "a belief that transgenderism is a normal and potentially healthy variation of human framework" (p. xix). Arguing that transgender expression endures stigma only when juxtaposed with a society that regulates acceptable gender behavior, Lev (2004) advocates a therapeutic model that respects and honors gender diversity. While she maintains the usefulness of psychotherapy in aiding those who grapple with transgender issues, Lev (2004) is critical of the psychomedical community's history of diagnosing and pathologizing transgender people. She views gatekeeping as unhelpful, reasoning that it "reinforces a lack of authenticity for the transgendered client, as well as the development of a false relationship between therapist and client" (Lev 2004:49).

Of course, health providers that abide by the *Standards of Care* limit therapists' agency in creating trans-positive models of health care. Indeed, many advocates for transsexual self-determination resist the classification of gender diversity as mental illness. GID classifications employ stereotypical notions of

gendered behavior, stemming from a medical model based on gender essentialism (Wilson 1997; Wilson 1998; Wilson and Hammond 1996). In order to cover mental health services, insurance companies typically require official diagnoses from the DSM (Spiegel 2005). While some members of the transgender community worry that removing GID from the DSM would completely remove medical justifications for hormone therapy and surgeries and further limit insurance coverage (Nangeroni 1996; Wilson 1997), some advocates recommend classifying transsexualism as a medical condition to remove the stigma of mental disorder and preserve eligibility for insurance coverage (Lobel 1996; National Coalition for LGBT Health 2004; Weiss 2004; Wilchins 1996). They reason that insurance companies already willingly cover the highly disputed reconstructive genital surgery for intersexed people (Nangeroni 1996). And framing transition services as purely medical makes training more likely to occur among doctors who administer hormones and surgeries (National Coalition for LGBT Health 2004). But some therapists are leery to embrace such a reformative policy.

Raj (2002) acknowledges that some advocates want complete removal of the therapy requirement from the SOC, but does not embrace this treatment model. Instead, he recommends general adherence to the SOC, including the imposition of the real-life experience, allowing some room for situational deviation (Raj 2002). As a transman, Raj (2002) asserts that trans-identified clinicians must still adhere to professional standards. His status as professional and transsexual surely guides this recommendation, thus limiting his ability to objectively critique the legitimizing agency that grants him authority and legitimizes his generation of business. Thus, his

recommendation maintains his professional credibility by advocating a collaborative compromise wherein therapists support clients and guide them in their decision-making. Similarly, Lev (2004) relies on her authoritative power as a gender specialist and the leniency allotted by the SOC to make individual exceptions to the proposed guidelines, stating "[i]t is often forgotten in the political battles that ensue regarding gatekeeping that the expertise of the clinician to make final decisions based on exceptional cases is undisputed" (p. 50). Unfortunately, the power of the therapist to determine what qualifies as "exceptional" to render an authoritative "final decision" undeniably remains disputable.

Pathologizing Transsexuality and Maintaining Binary Gender

Accepting the criteria for classifying human conditions as mental disorders is a subjective social process often fraught with political tension (Spiegel 2005). Between the third and fourth editions of the DSM, classifications of disorders rose from 180 to 297 (Shorter 1997), and the original book of 132 pages is now over 900 pages (Lev 2004). This upsurge begs the question of whether people in Western cultures truly are increasingly mentally ill. The process of determining what behaviors and practices count as mental disorders and defining the parameters of such classifications is clearly a socially constructed reality that differs across cultures and throughout history. Even demonstrating reliability of diagnosing remains challenging for psychotherapists who use the same diagnostic criteria set forth in the DSM (Spiegel 2005). Thus, the classification of transsexual inclinations as pathological

represents a tenuous and hotly contested decision informed by different social variables.

Rachlin (2002) stresses that transgender and transsexual identities are not in themselves pathological, and notes that trans people encounter problems similar to nontrans people that may lead them to seek counseling. Transgender people do not present uniform expressions of gender and sexuality (Bolin 1988), and in this way they are no different than nontransgender populations. Yet, transgender people must access transition-related health care under the guise of pathology, and may be expected to enact stereotypical gender expressions, or at least conceal contrary evidence (Monro 2000). Validating transsexuals through pathology "protects our cultural notions of the relations of genitalia and gender role and ensures that...gender will not be profaned by a permanent class of genital imposters" (Bolin 1988:54).

The institutionalized pathological classification of transsexuality secures the legitimizing roles of therapists in maintaining gender binaries, even when individual counselors are not invested in doing so. Indeed, many gender identity specialists in the mental health field regard themselves as authoritative in determining transgender meanings; their colleagues and many others regard them similarly (Weiss 2004). In the context of a constraining system of binary gender, psychomedical institutions manage transsexuals' gendered desires and identities as psychologically disturbed and in need of counseling (Monro 2000). This psychomedical management continues even after therapists use counseling to screen out people with schizophrenic manifestations from those with common transsexual desires.

Without strict societal adherence to dichotomous expression of gender, the atypical gendered paths that transsexuals crave would not need this type of authentication to progress. Societies with immutable gender rules view gender variance as dysfunctional (Weiss 2004) and in need of professional management. This reframed perspective informs the basis of psychomedical gatekeeping. Transsexual pursuits would be unremarkable and mundane without rigid notions of gender. Thus, the overarching authority of binary gender that informs psychomedical gatekeeping beckons analysis through the deconstructive lens of poststructural theory.

Poststructural Theoretical Framework

Inquiry into transmen's experiences within health care systems offers an important opportunity for poststructural theoretical insights, especially critical queer theory. Theories of gender that examine transgender issues have encountered criticism for disregarding transgender people's real life experiences (Ekins 1997; Felski 1996; King 1993; MacDonald 1998; Namaste 1996; Prosser 1995, 1998; Rubin 1996; Wilson 2002).[7] Advocates for the transgender community criticize these theorists for failing to incorporate issues such as accessing health care institutions and services (Namaste 2000). Even transgender theory developed by transpeople themselves is often limited to exploring issues of gender fluidity and subversion (e.g., Bornstein 1994; Wilchins 1997; Wilchins 2004). Recently, some social researchers have started to lay foundations for developing theories that incorporate abstract and lived transgender experiences (e.g., Cromwell 1999; Namaste 2000; Rubin 2003).

[7] For examples of theorizing about transgender without attention to transgender lived experiences, see Butler (2001), Lorber (1993), Roen (2002).

This burgeoning body of knowledge informed my research inquiry. Ultimately, however, my study benefited mainly from applying poststructural and queer theoretical frameworks to the findings that emerged from using grounded theory methods.

Poststructuralism's central point is that "discourse constructs meaning" (Hines 2006:50), a tenet crucial to understanding psychomedical gatekeeping. As part of the deconstructionist technique of poststructuralism, queer theoretical approaches also provided a useful framework for understanding the experiences of the transgender men in this study by undermining binary classifications of gender and sexuality (Whittle 2006). Issues that commonly affect transgender people dealing with identity formation, body politics, marginalization, and genealogies of power pervade queer theory discourses. In particular, Foucauldian interpretations of regulations of the body, medical discourse, and productive power represented highly useful tools for theoretical interpretation. Additionally, queer sociology complements theory by grounding gender manifestations and deconstructed identities within the macro level of various social frameworks (Hines 2006).

Poststructuralist theory lends insight into how some transgender communities deconstruct conventional gender classification (Hines 2006). Butler (2001) argued that transsexual surgery generates gender essentialist narratives, and that these narratives also aid in generating surgery. Without relying on dichotomous understandings of gender, convincing health professionals to confer medical transition would be a challenge (Butler 2001). The actual process of articulating

gender, then, is a social act that relies on interdependent and interactional meanings transcribed upon the body.

> The very criterion by which we judge a person to be a gendered being, a criterion that posits coherent gender as a presupposition of humanness, is not only one that, justly or unjustly, governs the recognizability of the human but one that informs the ways we do or do not recognize ourselves, at the level of feeling, desire, and the body, in the moments before the mirror, in the moments before the window, in the times that one turns to psychologists, to psychiatrists, to medical and legal professionals to negotiate what may well feel like the unrecognizability of one's gender and, hence, of one's personhood. (Butler 2001:622)

This theoretical claim is important to understand the ways transsexuals negotiate bodies within the pathologizing discourse maintained and expected by psychomedical institutions. Such theoretical techniques have not often been applied to transgender experiences within health care. When poststructuralists have considered these experiences, their theoretical analyses have left out empirical support. My research findings attempt to bridge this gap between theory and research.

Some theorists have suggested that the pathologization of transsexual bodies stems from patriarchal desires to instill gendered divisions in society. The creation of penal codes against gender deviations arose with patriarchal class divisions (Feinberg 1996), and patriarchal medicine has not valued gender identity clinics (Riddell 1980). Additionally, psychomedical institutions were historically male-dominated (Shapiro 1991). Examples of patriarchal treatments of transsexual bodies can be found in research. Some MTF transsexuals prefer women counselors, and report male therapists as imposing harsher views of what makes a woman (Bolin 1988). Stereotyped gender coaching within psychomedical contexts occurs (Shapiro 1991), and can contribute to hyper-femininity among transwomen, especially among those

who are more vulnerable and lack support (Bolin 1988). Other researchers have identified physicians who bullied potential MTF clients to assess whether they were really transsexual (Billings and Urban 1982), or gauged readiness for surgery on whether doctors viewed the MTF as physically attractive (Kessler and McKenna 1978).

Transgender populations are increasingly heterogeneous, and can include many gender identities and expressions that transgress conventional and dichotomous understandings of sex, gender, and sexuality (Bolin 1988; Raj 2002). One transsexual scholar argued, "Under the binary phallocratic founding myth by which Western bodies and subjects are authorized, only one body per gendered subject is 'right.' All other bodies are wrong" (Stone 1991:297). This normative construction of gender and gendered bodies supports binaries of gender and sexuality. Another transsexual scholar claimed, "Gender, like God, is a concept of the imagination that belongs within and supports the foundations of a patriarchal heterosexist hegemony" (Whittle 1996:210). The hegemonic maintenance of dichotomous gender informs how psychomedical institutions treat and manage transsexual bodies. The pursuit of cosmetic surgeries in normative gendered paths does not mean people are victims of patriarchy, but that all forms of body modification decentralize epistemological understandings of bodies (Sullivan 2006). For transsexuals, body modification becomes intelligible only through hegemonic interpretations of gender and sexuality.

Using poststructural and postmodern theory to explore transgender identity formation, Hines (2006) studied transsexual coming out narratives, recollections of significant moments, and linguistic discourses of identity. Transsexual people, like

nontranssexuals, manage gender throughout the lifetime (Hines 2006). Gender normativity and transgender identity construction relies on medical discourse to procure medical transition, despite disconnects between dominant discursive constructions of gender and transsexuals' articulations of identity (Hines 2006). In this study, Hines' limited use of poststructuralism failed to elaborate on transsexuals' reliance on the pathologizing discourse. Recently, Spade (2006) utilized poststructuralist techniques to understand his own experience with the discourse.

Spade (2006) published one notable exception that situated transsexuals' negotiations of health care systems within a poststructural theoretical framework. In a reflexive account using firsthand experience, Spade (2006) connected the legitimization process that trans people must negotiate in order to alter their bodies within a Foucauldian framework. This process epitomizes Foucault's concept of productive power (Spade 2006). "Foucault's model of power lends to a critique of the creation of categories of illness that serve, through diagnosis and treatment, to regulate gender expression" (Spade 2006:318). In his essay, Spade (2006) recognizes that gendered body alterations are only problematic in that "the medical regime permits only the production of gender-normative altered bodies, and seeks to screen out alternations that are resistant to a dichotomized, naturalized view of gender" (Spade 2006:319). Arguing for "deregulation of gender expression and the promotion of self-determination of gender and sexual expression," Spade (2006:319) suggests eliminating the gender stereotyping that occurs within psychomedical institutions. Through relaying his experience of changing his body, Spade (2006) identified

psychomedical gatekeepers as exercising Foucauldian disciplinary power by requiring gender normativity.

Transsexuals must assert a greater commitment to rigid gender binaries within psychomedical contexts because pathological classifications demand this subjectivity. Transsexual bodily pursuits endure extraordinary governance that restricts certain gendered paths, demanding external validation.

> Transsexuals are in a double bind—it is pathological not to adhere to gender norms, just as it is to adhere to them. The creation of the image of transsexuals as exemplary adherent to gender stereotypes requires an understanding of transsexuality that both fully accepts the medical definition of transsexual and ignores the multiple non-norm-adhering narratives that trans people produce outside of medical contexts (Spade 2006:328).

Health professionals within psychomedical institutions then function as "gatekeepers for cultural norms" who impose the "final authority for what counts as a culturally intelligible body" (Stone 1991:298). Passing as transsexual is then limited to successful normative gendered expression (Spade 2006). Consequently, transsexual subjectivity confirms nontranssexual subjectivities, allowing nontranssexuals to conceive of their own genders as normal and healthy (Spade 2006). While Spade (2006) applied this important poststructural framework to his experience with accessing medical transition, his analysis lacks empirical support and he bases his conclusions solely on his own personal journey. My research findings develop this idea, connecting theory to data analysis.

Drawing from this body of relevant literature and theory, the research presented in this thesis expands this literature by illustrating the ways transmen navigate psychomedical institutions in pursuing medical transition. My research compensates for gaps in the literature in the following ways. I focus attention to the

transmen population, an underrepresented group in most research studies. In contrast to historical medical and sociological analyses, I have no interest in explaining the etiology of transgender groups and instead harbor respect for gender diversity. Similarly, I reject some feminist traditions of problematizing transsexuality and do not hold transmen more accountable for perpetuating the gender binary any more than nontransgender others who express conventional gender. In other words, I do not insist that transmen defend their right to exist. This research elaborates on existing scholarly work that addresses the transsexual narrative, explaining the purposeful and strategic employment and of such storytelling. It explores gatekeeping in depth, resisting the oversimplification of doctor-patient interactions and contextualizing gatekeeping within a pathologizing framework. As a researcher—not a clinician—I have no stake in maintaining the SOC or rationalizing the need for their continued use. Finally, I incorporate the lived experiences of transsexuals and use their own words to try to understand their experiences, providing a grounding element to poststructural theory. Ultimately, this research will demonstrate that a pathologizing discourse informs transsexual pursuits of gendered body modification. However, transmen in this study negotiated this discourse in different and complex ways. They asserted their own subjectivities, manipulating and resisting this discourse at many points along their individual journeys.

Chapter 2—Methodology

Since little sociological research focuses on transmen's negotiations within health systems, I used qualitative research methods to address the central research questions of this project, as they suit research of an exploratory nature (Stern 1980). The constructivist paradigm that informs qualitative inquiry facilitates the dialectical interactions between research and respondents necessary in discerning evolving localities (Guba and Lincoln 1998). In addition, the lack of demographic information about transmen and the inability to obtain a representative sample would have limited the effectiveness of quantitative methods such as surveys.

Generating initial concepts and definitions demanded a less structured inquiry, and fostered my ability to unearth more complex ideas. Interviewing thus promoted an interpretative and historical method of understanding transsexual men's experiences (Weiss 1994). The open-ended interview strategy reflected feminist research methods that support representation of participants' perspective in their own words (Reinharz 1992). Qualitative methods typified the ideal strategy for exploring and understanding the social processes of transmen in health care systems. Finally, all research received approval from Georgia State University's Institutional Review Board.

Use of Pilot

While in a graduate course in sexuality studies during March of 2003, I conducted a preliminary inquiry into how FTMs defined being FTM and what sexual health concerns they considered important. I emailed these two questions to eight

FTMs within my social network and asked that they forward the questions to one other FTM. I received a total of eight responses. These replies partially aided the design for this project, specifically concerning issues related to sexual health care, identity, and the body.

The results from this pilot study indicated several key issues. Respondents underscored the importance of sensitivity and respect among health professionals, especially concerning appropriate language and the ways health providers responded to their bodies. Issues of identity remained important to many of these men. Reflecting on the assumptions about sexual identity, one man replied:

> When discussing their identity and "activity" don't assume the FTM is heterosexual. There are a lot of gay male FTMs. I think the biggest mistake made by health care providers (and people in general) have been their assumptions.

This pilot study also illustrated that even characterizing "FTM" varies. Based on responses from the pilot sample, I describe female-to-male transsexuals, or transmen, in the following way:

> Female-to-male transsexuals (FTMs) are people who were assigned a female gender or sex at birth based on biological anatomy who have chosen or plan to physically alter their bodies through the use of hormones and/or surgery to emphasize the male gender. FTMs may also identify as male, man, transman, transmale, new man, man of transgendered experience, intersexed, trannyboi, boi, genderqueer, third- or bi-gendered, and/or other identities that represent culturally defined masculine gender characteristics, and may identify as FTM without desiring hormones or surgery.

While some people may find this description flawed, I use it only to portray the respondents in this study broadly, and do not offer it as a definite and fixed characterization.

Though narrow in scope, this small pilot study alerted me to problems in describing transmen and provided insight on designing interview questions about sexual health. It reinforced my desire to consider the diversity of experiences among transmen without making assumptions about identity and behavior.

Data Collection Procedures

Since no reliable statistics on the transgender population exist, I relied on nonprobability snowball sampling techniques to locate and recruit participants. I contacted transmen within my own social network through email, inviting them to participate and asking them to forward my call for participants [Figure 2.1 and 2.2]. I also forwarded the call to lesbian, gay, bisexual, transgender, queer/questioning, and intersexed (LGBTQI) and transgender-specific organizations and posted the call on similar community listservs and websites. Wherever possible, I posted physical copies of the call on local community bulletin boards. I distributed palm cards at events that might attract transgender people, like Black Pride in Atlanta and at Southern Comfort, Atlanta's annual transgender conference.

Physically locating respondents in person proved to be difficult due to the lack of a viable FTM community in Atlanta. To my knowledge, there are no consistent events, support groups, or organizations that cater exclusively to Atlanta transmen. Therefore, most respondents in the study responded to an email they received. While transmen from different parts of the United States contacted me to participate, I opted to postpone phone interviews until exhausting all in-person meeting opportunities.

Fortunately, I met enough men in person so that I did not have to interview others via phone—an inferior means of establishing rapport and soliciting detailed replies.

In the beginning of the project, I collected data in two different ways. Primarily, I collected data through structured, open-ended interviews. In order to foster greater trust, I only interviewed participants in person. This strategy seemed important due to the sensitive nature of some of the questions that asked respondents to discuss personal issues related to their health and bodies. Establishing trust was imperative to me in studying a population that continues to be exploited by researchers.[8] I encouraged participants to choose the time and location for the interview so that they could select a comfortable atmosphere. I met respondents in their homes and offices, and in cafés and restaurants. I designed a flexible interview schedule that allowed me to explore apparent meaningful issues as they arose. The interviews ranged in length from 40 minutes to over three hours, and averaged about two hours each. I conducted all interviews and recorded them on a handheld audio tape recorder.

During the interviews, I sketched timelines of events and noted probes to present when the respondent finished speaking. This way I ensured that I asked all the questions that I wanted without interrupting the flow of conversation. At the end of each interview, I asked respondents to select their own pseudonyms. Once I transcribed each interview, I sent the respondents their transcripts to verify accuracy. I also posed clarifying follow-up questions at that time whenever needed. This member-checking strategy (Erlandson, Harris, Skipper, and Allen 1993; Lincoln and

[8] For a recent example of exploitation of transgender populations, see Bailey (2003). Bailey encountered criticism for researching transsexual women without their informed consent as research subjects and unscientifically claiming that transsexual women were autogynephilic sexual fetishists.

Guba 1985) allowed respondents the option to withdraw any information they felt uneasy about. However, none elected to do so. Only one respondent inserted minor commentary to clarify his meaning.

I conducted the interviews in several phases. I interviewed the first five respondents during the beginning of 2004. The second set met with me in May 2004. I then continued to interview men in the Southeast from the end of 2005 through June 2006. The gap in interviewing reflected problems balancing research with teaching and coursework. While I do not think the different data collection times significantly affected the findings, I believe that a later starting date coupled with more consistent immersion in the research would have propelled the project at a more reasonable pace.

The second method of data collection attempted to provide a visual and artistic element to the project. I provided the first nine respondents with a blank sheet of paper and pencil and requested that they draw their ideal bodies (or their best rough sketch of it). By requesting that respondents sketch their ideal body, I suspected I could parallel the sketched results with the interview questions that addressed this issue. I believed that these sketches would provide a visual representation of possible discrepancies between desired and actual bodies. I hoped the images would corroborate data from the interviews, providing an even more resounding portrayal. I employed this element of data collection as an unobtrusive research strategy to gain more understanding of a social phenomenon beyond the interactive processes of interviewing (Berg 2000).

While a participant sketched, I left the area to provide privacy. Once finished, I asked him to explain the image he drew and to elaborate on the drawing's contents. After implementing this method of collection to the first two sets of respondents (nine total), it became clear that this component did not add much to the project. The respondents provided detailed information about their feelings toward body image and surgical options verbally during the interviews. Additionally, the drawings left much to be desired. Many of the men were not great artists, and produced sketches that were unclear and a bit messy. Some drew naked bodies, while others drew clothed bodies. One man drew a limbless naked torso. While these naked images best illustrated any discrepancies between ideal and actual bodies, I felt uncomfortable requesting nude renderings. It felt a bit voyeuristic and creepy. As I considered what this group of sketches possibly added to the study, I concluded that they did not significantly impact emergent findings. Thus, I abandoned this method after interviewing the New York City respondents.

Sample Description

A main goal in this study was to learn about negotiating gendered bodies within transgender-specific and general health care systems. To participate in this study, transmen must have altered their bodies through hormones or surgery to reflect their desired gender. While experiences of these FTMs and FTMs who do not use hormones or surgery may overlap, I believe that transmen accessing medically-regulated transition have more consistent and recurrent experience with health care systems specifically related to transgender services. They sustain contact with health

professionals that administer trans-specific services, such as endocrinologists and plastic surgeons. Additionally, the physical changes that hormones and surgery cause affect these FTMs differently in terms of health care needs, negotiation of identity, and issues with the body. Therefore, I believe that the health care experiences of transmen who do not choose medical transition are certainly valuable and worthy of investigation in another study.

Respondents in this study lived in two primary regions: greater New York City and the Southeast region of the United States.[9] I ultimately interviewed 21 people. Twenty of these men were female-to-male transsexuals. To illuminate potential differences in treatment, I used a comparative case study of one intersexed person who was socialized female and accessed medical masculinization in adulthood to reflect a male gender. As a fairly new resident to Atlanta, my involvement with the transgender community was limited, and I was unsure how many transmen I would be able to interview. Knowing I would visit New York at least twice, I utilized FTM contacts there for snowball sampling to find initial respondents. I also anticipated that having men from two different regions might enrich the findings and produce broader implications. Ultimately, nine respondents lived in greater New York City, four lived in Atlanta, and seven lived in small towns or rural areas (two in North Carolina and five in Georgia) at the time of the interview.

Three men who initially agreed to participate did not end up in the sample. One man withdrew from the study due to severe health problems that warranted neurosurgery and lengthy recovery time. Another man expressed wariness about how the research would represent him. Through communication and explanation of the

[9] For an overview of demographic information, see Table 2.1 on page 44.

goals of the research, he agreed to participate. But because he still expressed uneasiness, I decided not to include him to protect his safety. The third man who wanted to participate was a student at Georgia State University who enrolled in my class. Although he eventually dropped the class before the semester began, I did not interview him due to ethical concerns for student privacy.

Other demographic information I asked of respondents included their ages, current living arrangement, place type of upbringing, race and ethnicity, occupation, gender identity, and sexual identity. Respondents ranged in age from 20 to 57 years old, with an average age of 33.3 and a median age of 29.5. Seven men lived only with their partners, five lived with friends, one lived with a partner and friends, one lived with other family, three lived with roommates, and three lived alone. Concerning their upbringing, seven men described growing up in urban areas, four grew up in suburban areas, one grew up in a small town, four grew up in rural/small town areas, two in rural areas, one in both urban and rural environments, and one in both urban-suburban and rural areas. Despite outreach efforts to LGBTQI people of color sites and organizations, white men were over-represented in the sample. Eleven men described their race and ethnicity as white, four as white and Jewish, and one man each identified as American Indian and African American, Native American and Jewish, Greek and Russian Jewish, Afro-Caribbean, and German and Hispanic.

The men in this sample worked and studied in a variety of areas. At the time of the interview, four were full-time students in law, photography, marine science, and a nonspecified field of study. One of these students worked as a part-time legal worker, another as a part-time photographer, and another as a part-time web

researcher for a publishing company. One man in the study was currently not working but expected to work within a week—he previously supervised court liaisons for children and family services. One man worked as a community organizer while formally studying Eastern medicine. Two men worked as coffee shop baristas, one of whom believed his true work was as an outreach coordinator at his ministry. Another man managed a coffee shop. One man worked as a waiter/actor. Of the overtly working-class professions, one man worked as a delivery driver, another worked as a courier for a national company, another did temporary construction work, and another man was on disability from working as a trucker and was self-employed in a small business in town. On the other end of the occupational class spectrum, one man worked as an attorney. Two men were health care providers themselves; one was a clinical social worker and another worked as a physical therapist. Another man worked as a secretary at a nonprofit health care company. One man worked as a copy editor and another described his occupation as a writer, pornographer, and sex educator. Of all these men, eight worked or actively volunteered in places geared toward the LGBTQI community, so they had high levels of involvement with the trans community.

Asking respondents how they would describe their gender identities elicited diverse replies. Many of the men described their gender identities in nonlinear and nonbinary terms. Eight men provided singular answers without elaboration, including three who described their gender identity as male, three as transmale, one who described his gender identity as man, and one as female-bodied man. Two men said they identified as male or FTM, depending on the context. Two said they identified

as male and FTM. One said his gender identity was male trans / transmale, another said his gender identity was F-to-M and trannyboy. Six respondents described their gender identities in multiple terms. One respondent described his gender as female-to-male transsexual, transsexual man, transgendered man, and man. Another interviewee described his gender identity as male, guy, and transguy. Yet another described his gender as FTM, transguy, guy, and transman (but said he felt uneasy about the "man" part of transman). One interviewee described his gender as queer, but liked the term transman, while another said his gender was fluid but he liked the term transguy. Finally, one respondent said describing his gender identity was "a struggle," but conceded that he liked the term "transman." Obviously, many of these research participants spent a lot of time thinking about what gender means to them. Their sexual identities were no less complex.

Much like their nonlinear gender identities, respondents in this study largely avoided dichotomous understandings of sexuality that relied on the gender binary. Eight people identified in singular terms, with three respondents describing their sexual identities as gay, three as straight, and two as bisexual. Four others described primarily heterosexual sexual identities, with one identifying as "basically straight" and another as "mostly straight." One heterosexually oriented respondent identified as heterosexual but said that he also "embraced a queer identity." Similarly, a fourth respondent described his sexual identity as "hetero-queer." The final eight respondents embraced queer or open sexual identities. Four respondents identified as queer, regardless of how they partnered. One identified as queer and pansexual fag, while another identified as fag and queer. One said that he dated people of all

genders, felt resistant to labels, and was in an open relationship with a woman.

Another described his sexual identity as fluid and said he dated all genders.

Table 2.1: Respondents' Demographic Characteristics

Age	
20-25	3
26-30	6
31-35	6
36-45	3
46-60	2
Upbringing	
Urban areas	7
Suburban areas	4
Small town	1
Rural/small town areas	4
Rural areas	2
Both urban and rural areas	1
Both urban-suburban and rural areas	1
Residence	
New York City	9
Atlanta	4
Small town/rural area in Georgia	5
Small town/rural area in North Carolina	2
Living arrangement at time of interview	
Living with partner only	7
Living with partner and friends	1
Living with friend(s)	5
Living with other family	1
Living with roommate(s)	3
Living alone	3
Race and ethnicity	
White/Caucasian/European American	11
White and Jewish	4
German and Hispanic	1
Native American and Jewish	1
Greek and Russian Jewish	1
American Indian and African American	1
Afro-Caribbean	1
Primary employment	
White collar professions	3
Serving professions	7
Working class professions	3

Creative/artistic professions		1
Students		4
Disability		1
Unemployed		1
Gender identity		
Singular term, no elaboration		8
Male	3	
Transmale	3	
Man	1	
Female-bodied man	1	
Contextual term		2
Male or FTM	2	
Dual terms		4
Male and FTM	2	
Male trans / transmale	1	
F-to-M and trannyboy	1	
Multiple terms		6
Female-to-male transsexual, transexual man, transgendered man, man	1	
Male, guy, transguy	1	
FTM, transguy, guy, transman	1	
Queer, transman	1	
Fluid, transguy	1	
“A struggle,” transman	1	
Sexual identity		
Singular term, no elaboration		8
Gay	3	
Straight	3	
Bisexual	2	
Primarily heterosexual		4
Basically/mostly straight	2	
Hetero-queer	2	
Queer/open		8
Queer	4	
Queer and pansexual fag	1	
Fag and queer	1	
Date all genders, open relationship w/woman	1	
Fluid, date all genders	1	

Considering the multiple ways that respondents describe their gender and sexual identities, I acknowledge that describing them in singular identity terms poses potential problems. Due to the varied ways respondents identified and described their

genders, I vary terminology throughout this thesis, alternately describing the sample as men, transmen, FTMs, transgender and transsexual men. For the purposes of this study, respondents' transgender status is crucial. Readers should note that these respondents each move through the world as men and are perceived as men in their everyday interactions. I employ singular terms for the sake of brevity only, and hope that readers will recall their more intricate identities when thinking about issues related to gender. When complicated identities impacted data analysis, I accounted for these variances. For the purposes of this study, I do not think gender identity differences affected the central findings I argue in this thesis. I do, however, believe that their thoughtful reflections on gender and sexuality warrant further development and lend empirical credence to studies in queer theory. I anticipate returning to this issue in a separate paper.

More important in this analysis are the ways that these men accessed medical transition to achieve their desired gendered bodies. Every transman in this sample used injectable testosterone (or "T") at the time of the interview. The hormone dosage ranged for transmen, from 50mg to 100mg every week or 200mg every two weeks. Many of these men's dosages changed over time, and some had accessed testosterone through pro-hormone sprays, creams, testosterone gel patches, and trans-dermal troches. The amount of time they had been on testosterone ranged from 1 to 20 years, with 4.3 being the average amount of time and 3 years being the median amount. Due to transmen's tendency to disappear or go stealth after transitioning, I was unable to locate many men who were well into transition. Therefore, the sample largely reflects biases of those men who are pretty early into transition.

Concerning surgery, the most common surgery among the sample was chest reconstruction surgery through double mastectomy. Of the 20 respondents, 15 had gotten top surgery. Only three transmen had hysterectomies, and one of them had his surgery prior to transitioning. Only one transman had gotten genital surgery. This respondent had a metaoidioplasty, which frees the enlarged clitoris-phallus from the pubic bone, along with a scrotoplasty, or silicone testicular implants. Two other transition-related surgeries were part of this sample. One transman had liposuction of the hip and thigh area, and another had an endometrial ablation—removal of the lining of the uterus. Of the men who had surgery, most accessed hormones before surgery (13 out of 16). Overall, the transmen in this sample had been accessing medical transition from 1 to 20 years, with an average of 4.3 years.

Transmen in this sample accessed medical transition through a variety of health providers and places. They utilized services of general health care providers and internal medicine practitioners through private doctors, primary care providers, nurse practitioners. They also accessed specialist providers, like endocrinologists, gynecologists, and plastic surgeons. Transmen in this sample saw these health providers in private offices, public community health clinics, LGBTQI community health clinics, women's health centers, and university clinics. They encountered assorted types of providers in different health care sites.

One major unifying factor in accessing care was the way respondents accessed mental health care in order to secure transition-related medical procedures. Almost all of the respondents in this sample saw a psychologist, counselor, social worker, or

other licensed therapist in order to gain approval for medical transition. I will explain these processes in more detail later, as they represent a core process of this research.

Table 2.2: Accessing Medical Transition

Therapy to authorize medical transition	16
Hormone therapy	20
Chest surgery	15
Hysterectomy	3
Endometrial ablation	1
Genital surgery	1
Liposuction	1

Data Analysis Procedures

Analyzing the data through conventional grounded theory methods allowed me to explore concepts and develop themes directly from data (Strauss and Corbin 1998). I prepared data for analysis by numbering each line in the interview transcripts and allowing three inches of margins on the right to provide space for notes. Grounded theory techniques allowed me to generate concepts derived from the actual data. I began by reading through each transcript in its entirety to develop a general impression, jotting brief notes in the margins for further exploration. I applied open coding to data from the first 12 interview transcripts using line-by-line analysis, and later in analysis coded selectively based on emergent themes (Strauss and Corbin 1998).

In this process, I identified indicators within the data that suggested emergent concepts. I underlined indicators of concepts on the transcript, circled words and terms that seemed particularly important, placed quotation marks around potential in

vivo codes, and framed temporal signifiers in parentheses. In this stage, my margin notes contained preliminary attempts to think about key concepts in terms of their properties and dimensions. I also noted ideas about implied meanings, attending to causal inferences with signifying words like “because” and “since.” Due to the chronological nature of some trans-related care, I created transitional trajectories for each interviewee. These trajectories marked the ages when respondents encountered major moments of transition-related health care (e.g., transgender realization, chest surgery, hormone therapy). These timelines allowed me to gain an overarching perspective of transmen’s negotiations within health care systems. After microanalyzing each of the first 12 transcripts, I then listed codes of the emerging concepts, giving them abbreviations and applying these codes to subsequent transcripts. Throughout the process, I continually noted new concepts and meanings and assigned new codes.

During open coding, I used the indicator-concept model to compare indicators, noting their similarities and differences in forming concepts (Strauss 1987). These concepts denoted phenomena detected in the data, and formed initial theoretical directions (Strauss and Corbin 1998). The actual analytic process of open coding revolved around deliberately dissecting, carefully examining, and scrutinizing the data for comparative purposes (Strauss and Corbin 1998).

The process of open coding allowed me to move from the development of concepts to the development of categories so that I could build theory (Strauss and Corbin 1998). This act of labeling concepts represented an initial step in representing the meanings of the data (Strauss and Corbin 1998). When other data indicated

similar ideas as previously outlined concepts, I compared the meanings of these indicators through the constant comparative method, a central feature of grounded theory methods (Glaser 1965; Glaser and Strauss 1967). This process enabled me to examine concepts more closely and to deepen analysis, thinking in terms of their tentative properties and dimensions (Strauss and Corbin 1998). Abstracting concepts into more general categories facilitated the development of concepts into categories, reflecting the characteristics and ranges of phenomena (Strauss and Corbin 1998). I was then able to investigate relationships between and among categories for their explanatory and predictive abilities (Strauss and Corbin 1998).

A crucial aspect of the analytical process involved writing reflective, coding, methodological, and theoretical memos. This process generated seven revisions of code lists containing nearly 100 categories throughout axial coding—relating categories and subcategories to each other—and allowed me to add and trim categories as the research evolved [Figure 2.3]. I maintained drafts of code lists, consolidating, regrouping, and rephrasing categories based on analyses. I organized them by theme, and by individual-level and interactional concepts.

Through axial coding, I focused on one category at a time, examining its axis in relation to all generated categories and subcategories (Strauss 1987). I directed close attention to each individual category, intensely analyzing for various links to all other categories (Strauss 1987) and attempting to link categories on the conceptual and dimensional level. In this way, I systematically connected categories beyond superficial descriptions in order to build theory (Strauss and Corbin 1998). In this process, I was able to develop more detailed explanations about phenomena by

contemplating categorical interrelationships in contexts of paradigmatic conditions (Strauss and Corbin 1998). For example, when respondents described a health provider as "sensitive," I interrogated this meaning in the broader context of his overall experience with this provider (e.g., fleeting versus continual care), within the health care context (e.g., clinic doctor versus chest surgeon), and in relation to the other emergent concepts, ultimately characterizing provider sensitivity as part of the broader category of "Transgender Awareness."

On both micro and macro levels, I studied causal, intervening, and contextual conditions, structure and process, and intersecting interactions (Strauss and Corbin 1998). This process in data analysis reflected a more focused coding process, attending to systematic interconnections between categories (Charmaz 1983). I was able to link related groups of individual categories to other groups of categories. For example, I found that researching transition placed respondents within a network of information where they encountered myriad messages about the health care system. This process of collecting information prepared respondents for accessing medical transition, aided in their development of strategies for interacting with providers, and provided points of comparison between their own experiences and those of other transmen. At this stage of data analysis, I was able to develop a trajectory of events not just related to the transition from female to male, but the actual progression of contemplating gender as a whole.

Thus, I was able to code for process by examining the temporal effects of actions and interactions with changing structural conditions (Strauss and Corbin 1998). I attended to the rhythm of the data, noting routine and strategic responses

that evolved purposefully among respondents (Strauss and Corbin 1998). In comparing categories, I noted how different interviewees managed or failed to manage various situations. These comparisons enabled me to evaluate divergent reactions to psychomedical gatekeeping, for example. I examined their strategies for dealing with different issues they encountered as related to the dimensions of each category. I coded for these assorted processes, remarking on my interpretations in analytic coding memos. I was then able to formulate relational statements about these conceptual relationships, deciding on further data collection steps to develop and enrich categories (Strauss and Corbin 1998). With clear themes emerging from the data, I revised the interview schedule to elicit more detailed responses in these areas. Ultimately, I settled on the fourth draft as the final guide for questioning [Figure 2.4].

I employed another valuable grounded theory method through diagramming. Throughout analysis, I drafted diagrams to reflect relationships between categories. I diagrammed categories on micro and macro levels, according to how they fit into the overall schema. This method represented a key part of axial coding, as I connected categories based on their different dimensions. I made numerous diagrams and kept a bulletin board of all the categories, tacking them to the corkboard in an organized manner as the relationships deepened. This corkboard allowed me to consider alternative arrangements as I easily moved the categories around in the overall schema. This process of axial coding led me to select the primary core category of this project, psychomedical gatekeeping.

While sampling limitations restricted theoretical sampling possibilities, I did attempt to interview men from diverse perspectives and with varying experiences. As

data analyses progressed, I identified areas that needed elaboration and attempted to include men who could address these issues. For example, during early stages of axial coding, I realized the importance of including at least one man who had transitioned more than 10 years ago and one who had only recently begun transition. In this way, data analysis informed data collection. I employed this strategy as often as possible, although the small population of transmen compromised traditional theoretical sampling techniques.

A primary goal in grounded theory methods is to achieve theoretical saturation—when further data collection no longer meaningfully or substantially contributes to emergent categories and new information differs only slightly (Strauss and Corbin 1998). I obtained theoretical saturation of the main themes in the data. After open coding 12 interviews, line-by-line analysis rarely lent anything novel to categories (Strauss 1987). Indicators began to reflect the same idea, only differing in minor detail. I basically exhausted comparative relationships and subsequently saturated categories (Strauss 1987). While I obtained new inflections of data, these did not contribute much to analytic explanation (Strauss and Corbin 1998). At this point, I felt like the sole purpose of some of the interview questions was to provoke more quote-worthy responses and selectively coded the last set of interviews.

The process of selective coding represented a final step in grounded theory methods where I refined my theory of psychomedical gatekeeping generated from the data analysis (Strauss and Corbin 1998). After outlining the basic structures from axial coding, I dropped categories that seemed extraneous due to their lack of sufficient indicators or connection to the general theme in order to trim my theory of

psychomedical gatekeeping. By integrating theory in analysis, I was able to identify the central or core category (Strauss and Corbin 1998). The core category of psychomedical gatekeeping possessed strong analytic power to describe the relationships between all other categories (Strauss and Corbin 1998). It met the six criteria for selecting a core category in that it was central, appeared frequently in the data, explained categorical relationships logically, lent general theoretical relevancy, produced strong explanatory power, and accounted for variation (Strauss 1987; Strauss and Corbin 1998). I then refined my psychomedical gatekeeping theory for consistency, relevancy, and schematic validation (Strauss and Corbin 1998). Psychomedical gatekeeping, as a core category, also represented a meaningful sociological concept applicable to more general theoretical concerns pertaining to gender.

Strategies for Validating Findings

To strengthen the accuracy of the findings, I used a variety of strategies supported in qualitative research. As part of grounded theory, I interacted with the data, constantly thinking about meanings and directions of interpretations. For example, when a respondent first mentioned psychomedical gatekeeping, I wondered about how such instances impacted his experiences with health care and what they meant on macro levels of regulating gender through psychomedical institutions. I then contrasted his experiences to others, noting discrepancies and similarities that provided more information about the concept. My verification procedures also included making deductions and checking them with the data (Strauss 1987). I

continually examined the data to support, confirm, or challenge ideas developing throughout analysis. In addition, my writing incorporates rich descriptions of the findings to provide readers with a greater sense of sharing in the experience.

To further validate findings, I used the member-checking strategy by relaying ideas back to participants to assess their perception of the accuracy of the research. After interviews ended, I talked with respondents about emergent findings, asking them their thoughts on the different themes. Our interviews often led to more casual intellectual conversations about transgender issues. Since participants agreed with my musings about how psychomedical institutions often impose regimented standards of care based on assumptions about transgender identity, I assumed I was not off base. Respondents seemed interested in my thoughts and appeared to agree with my theoretical conclusions.

Methodology Strengths and Limitations

The qualitative method of inquiry I employed offers many advantages. The in-depth interviewing strategy afforded me the ability to learn about respondents' experiences in great detail. Respondents often reported that they thought I covered every aspect of their health care experiences. I also employed feminist methods that enabled the presentation of data in respondents' own wording, thereby emphasizing the perspectives of the respondents in the findings (Reinharz 1992). Finally, using grounded theory methods allowed me to develop ideas based on the actual data, and prevented me from imposing my own hypotheses. The findings represent data-driven concepts that emerged despite any preconceived notions I had about transmen's

experiences with health care. This research strategy fostered my ability to avoid positivistic epistemological and ontological truths.

My research methods also presented several limitations and challenges. The nonprobability sampling procedure and small sample size preclude findings generalizable to the FTM population. Almost all of the men in this sample had internet access and learned of the study through email, thereby excluding men in more isolated and poorer communities. The FTM population chosen for sampling only included individuals who have physically altered their bodies through hormones and/or surgery. The study neglected insights from people who identify as FTMs or transmen and do not utilize medical transition for personal, health, or financial reasons. In addition, my bias as an ally and member of the transgender community informed my subjective position of thinking that transgender identities and experiences do not represent pathological disorders and should not be understood through this restrictive and oppressive lens. But of course, I adhered to professional guidelines on conduct, and presented all information honestly, regardless of whether it contradicted my themes, in order to foster greater credibility.

Overall, the research methods provided an excellent means for understanding this unique population. The dialectical face-to-face interactions between respondents and me contributed to comfortable environments that enabled discussion of fairly personal issues related to health, identity, and the body. In-depth interviewing provoked detailed responses that translated into rich data and clearly illuminated concepts. Through this study, I have produced findings that contribute to sociological

literature on ways that psychomedical institutions regulate and enforce dichotomous gender systems.

The next section of this thesis discusses the primary findings of the study as they relate to psychomedical gatekeeping. I will describe how transmen represent informed consumers when accessing health care and how this subjectivity directs their decisions to negotiate health care to obtain desired bodies. And since transsexualism retains its classification as a mental disorder in the *Diagnostic and Statistical Manual*, these transmen must authenticate their gender identities through the confines of pathology in obtaining approval to change their bodies.

F T M

Calling all FTMs and transmen living in the Southeast

If you are a **man of transgender experience** who has physically altered your body through the use of hormones and/or surgery to emphasize the male gender, you are invited to participate in a research study that focuses on developing an understanding of issues that are important to the health of FTMs.

I am interviewing FTMs and transexual men for a study on understanding experiences associated with accessing and receiving health care.

Comic
here.

All information you provide is strictly confidential.
You do not need to use your real name.

For more information, please contact Elroi Waszkiewicz:
(404) 354-4945 elroiw@gmail.com

This study is being done by a graduate student at the Department of Sociology at Georgia State University and is IRB-approved.
The researcher is a transperson and the research may be useful in advocating for transmen's health concerns.

Figure 2.1

Call for Participants—Poster (Final Version)

Calling all FTMs **Living in the Southeast** Participants needed for a study that seeks to understand the experiences of FTMs and transexual men associated with accessing and receiving health care. If you are a man of transgender experience who has physically altered your body through the use of hormones and/or surgery to emphasize the male gender, you are invited to participate in a research study that focuses on developing an understanding of issues that are important to the health of FTMs. This research is led by a transperson and may be useful in advocating for transmen's health concerns. All information you provide is strictly confidential. You do not need to use your real name. This study is part of the Department of Sociology at Georgia State University. For more information, please contact: 404-354-4945 elroiw@gmail.com	**Transman** **FTM** **Female 2 Male** **New Man** **Man of Transgendered Experience** Trannyboi Man Trans-Male F2M MtM Transexual Man **contact the researcher,** **Elroi Waszkiewicz,** **for further information:** 404-354-4945 elroiw@gmail.com

Figure 2.2

Call for Participants—Palm Card (Final Version)

Gender Categories
Sexual identity and attraction shift.
Relationship with the transgender community.
Out as transgender.
Pretransition body image.
Posttransition body image.
Coming to terms with the limitations of a transgender body.
Feeling connected to body.
Movement through the world.
Aesthetic satisfaction with body.
Genital surgery as aid in relieving body image.
Thinking about gender during childhood.
Thinking about gender during adolescence.
Thinking about gender during pretransition adulthood.
Considering transition.
Sites of researching transition.
Network of information.
Messages about technicalities of transition.
Messages about reputation of health providers.
Hearing transgender horror stories.
Fearing the emergency room.
Perception of risk in transitioning.
Messages about medical gatekeeping or approval process.
Invoking the "typical true transsexual narrative."
Finding alternatives to medical transition.
Thinking about gender during posttransition adulthood.
Transgender identity as special.
Transgender identity as longtime battle.
Transgender identity as handicap or liability.
Transgender identity as affecting romantic life.
Barriers to ideal physical self.
Talking specifically about wanting a penis (or not).

Current Health Care
Accessing general heath care (not trans-specific).
Accessing mental heath care.
Accessing hormones.
Accessing surgery.
Self-awareness of health needs.
Feeling apprehensive about accessing health care.

Interactions within Health Care

Health Provider Responses

Transgender Awareness.
Providing information.
Bedside manner.
Sexuality communication.
Ability to listen and be receptive.
Negotiating language.
Bizarre or inappropriate communication.
Scolding.
Denying care.
Gatekeeping.
Problem-Solving and advocating.
Educating public about transgender issues.
Skills of health provider.
Support staff response.
Treatment toward patient's family.
Intentions of health provider.

Patient Responses

Understanding health provider's reasoning.
Willingness to educate health provider.
Confronting health provider.

Strategies before Accessing Health Care

Legal name or gender change on identifying documents.
Calling beforehand.
Enlisting help of others.
Meditating or praying before accessing health care.

Strategies while Accessing Health Care

Accessing health care with someone.
Negotiating and navigating spatial dynamics of health care site.
Staying on guard**.**
Stating language preference.
Asking about health care.
Guarding paperwork

Strategies after Accessing Health Care

Meeting with supervisor of health provider.
Changing health provider.

Hormones
Decision to start hormones.
Satisfaction with hormone effects.

Surgeries
Surgery decision.
Satisfaction with surgery.
Surgery regrets.
Waiting for better surgery.
Future surgery plans.

Satisfaction with Health Care
Feeling lucky
Experience in comparison to other transmen
Privilege as aid (demos, access, support, entitled)
Health Insurance Coverage
Realizing limitations
Desire for more/better information/research/surgery
Desire for sensitive providers

Figure 2.3

Code List 7 (Final Version 3-5-06)

Revised June 1, 2006
After NYC Analyses

IDENTITY

Current city/state/type of area, where grew up, current living arrangement
Occupation, age, race/ethnicity
Gender identity? Sexual identity?
Relationship to TG community, if any? Out as trans?

How has being TG affected how you view/experience your identity?
Has your gender or sexual identity changed since you starting identifying as trans?

What trans-related services have you accessed? [hormones, surgery, counseling]
Ages for each? [timeline]

First transition step: What led you to ultimately decide to access transition?

COUNSELING

Messages: What have/had you heard about counseling?

- Easy/difficult process, time limits, professional protocol?
- Messages from where? People, internet, support groups, books

What made you ultimately decide to start counseling?
Walk me through experience with counseling.

- Where, type of provider, support staff
- Time limit requirement, letter, content of letter, diagnosis?

How satisfied were you with counseling?
Would you have accessed counseling before starting transition if it wasn't required?

- Why or why not?

HORMONES

Messages: What have/had you heard about T?

- Easy/difficult process, time limits, professional protocol?
- Messages from where? People, internet, support groups, books

What made you ultimately decide to start taking T?
Walk me through experience with accessing and starting T.

- Where, change in provider, support staff, pharmacist, dosage, inject/gel
- require letter/gender verification

How have your experiences been with providers regarding T?

- Satisfied w/interactions? +/- experiences?

How satisfied are you with the effects of T? Likes/dislikes?

SURGERY
Messages: What have/had you heard about surgeries?

- Easy/difficult process, time limits, professional protocol?
- Messages from where? People, internet, support groups, books

What made you ultimately decide to get surgery?
Walk me through experience with accessing and getting surgery.

- Where, choosing provider, support staff, require letter/gender verification

How have your experiences been with providers regarding surgery?

- Satisfied w/interactions? +/- experiences?

How satisfied are you with the surgery results? Likes/dislikes?

TRANSITION SATISFACTION
How have hormones and/or surgery affected your satisfaction with your body?
How is your ideal body different from your present body, if at all?

GENERAL HEALTH CARE
Messages: What have/had you heard about general health care for transmen?

Can you tell me about your present health care overall?

- Regularity, types of providers, sites of health care, insurance coverage
- Sexual health
- ER
- Denied care?

How have experiences w/accessing & receiving HC changed since you transitioned?
+/- experience?

On a scale of 1-10, how would you rate your overall satisfaction with accessing and receiving health care (10=extremely satisfied)?
How do your experiences compare to other transmen? Better or worse?

- What do you attribute that to?

Biggest concern regarding health care?
Strategies used to get better care?

Is there anything else you want to express that we have not discussed?
Pseudonym?
Spread word?

Figure 2.4

Interview Schedule—Final Version

Chapter 3—Becoming Informed Consumers

> *The autobiographical act for the transsexual begins even before the published autobiography—namely, in the clinician's office where, in order to be diagnosed as transsexual, s/he must recount a transsexual autobiography. The story of a strong, early, and persistent transgendered identification is required by the clinical authorities, the psychiatrists, psychologists, and psychotherapists who traditionally function as the gatekeepers to the means of transsexual "conversion." Whether s/he publishes an autobiography or not, then, every transsexual, as a transsexual, is originally an autobiographer. Narrative is also a kind of second skin: the story the transsexual must weave around the body in order that this body may be "read".... [T]ranssexuality emerges as an archetypal story structured around shared tropes and fulfilling a particular narrative organization of consecutive stages: suffering and confusion; the epiphany of self-discovery; corporeal and social transformation/conversion; and finally the arrival "home"—the reassignment. In their formality, in their function as figures of self-reflection, mirror scenes serve to elucidate this formalization of transsexuality as a plot.* –Jay Prosser (1998:101), on relaying the transsexual narrative

In understanding the ways transmen deal with psychomedical gatekeeping, it is useful to first appreciate how they enter into systems involving psychological and medical care. A key finding in this research is that transmen begin transition as informed consumers who must medically change their bodies within the confines of pathology since psychomedical communities view transsexuality as a mental disorder. While researchers have traced pathological roots of many forms of body modification (Gorbis and Kholodenko 2005; Sarwer et al. 1998), surgeries that enlarge breasts or staple stomachs do not require preauthorizing letters from therapists. Transmen therefore represent a unique population of informed consumers of transition services because psychomedical institutions view changing sex and gender much differently than other procedures that change bodies. If a transman wants rhinoplasty, calf implants, gastric bypass surgery, or even devil horns strategically implanted into his head, all he needs is cash and his signature on a release form. If, however, he wants a surgery that shifts his

gender status, he needs a therapist to verify his sanity and ability to make decisions about his own body. This chapter illustrates the ways that transmen prepared to experience and negotiate psychomedical gatekeeping through becoming informed consumers and manipulating the pathologizing discourses of transsexuality.

The process of becoming informed consumers occurs before medical transition and while accessing new transition-related procedures once transition has begun. Before transition, transmen in this sample spent long periods of time thinking about gender and considering transition. This process involved serious personal reflection. Transmen in this sample devoted considerable research into transition through transgender networks of information. Within these networks, transmen encountered a variety of messages that educated them about what to expect in transitioning. They learned about hormones and surgeries, and heard about reputable providers. They also encountered horror stories about transgender experiences with health care. By becoming informed consumers, transmen in this study learned that health professionals viewed their body alteration desires as symptomatic of mental disorder and thus became prepared for psychomedical gatekeeping. They typically entered the offices of doctors and therapists armed with a great deal of information. In effect, these transmen were ready and willing to do what they needed to do and say what they needed to say to get that “golden ticket”—the therapist letter—in order to obtain their desired bodies.

My research allowed transmen to describe their experiences with health care from the time period before they accessed services to the care they received at the time of the interview. I inquired about how they entered into transgender-specific care, and the messages they heard about these services before they actually accessed them themselves.

In discussing these experiences, transmen relayed individual trajectories of thinking about gender and transition. The period of considering transition placed transmen in this sample into influential networks of information where they learned about what becoming a transgender man entailed.

CONSIDERING TRANSITION

For most of these men, the decision to transition was not easy, and involved lengthy periods of self-reflection and contemplation about obtaining their desired gendered bodies and achieving self-actualization. For many transgender people, changing one's body to reflect one's desired gender characteristics is a crucial part of self-actualization. Meaning, transition is part of realizing "the potentialities of the self," an evolved process of becoming psychologically healthy through "the idea that each individual has a lot of hidden potentialities: talents or competences he or she could develop, but which have as yet not come to the surface" (Heylighen 1992:42). The process of thinking about gender and transition started in childhood for some men, and lasted only a few years or months for others. Micah carefully considered starting testosterone over several months, even though he knew he wanted the changes that hormones would bring:

> Oh, I just knew it was right for me. It was like, when I first started reading about hormones, I was just very excited about the physical changes that could happen. And also excited about the fact that I wouldn't be taken as female as often, which was always unpleasant for me. I didn't make up my mind right away. I went through a few months when I was sort of agonizing, thinking about like, I might lose my fiancé. I might get rejected by my family and friends. I might not be able to afford it. I might not be able to jump through all the medical hoops. And also thinking, should I really be doing this when I'm not absolutely sure that I'm a man, when I just know that I'm not a woman....[laughs] And then I did a couple months of all this thinking things through and then finally I was like, I'm just

> torturing myself. I've known from that absolute first time that I saw anything about hormones that I wanted to do it. Like, on a gut level I knew that it was right for me. I wanted the physical changes, I wanted the social changes. So, I just decided to go for it.

Like Micah, Leroy also took time to consider transition, even trying to envision himself as a man without utilizing medical services. His struggle exemplified the seriousness with which many transmen contemplate transitioning:

> At the age of 21, I was with this woman that I was pretty in love with, and she was the first person I ever felt like I was in love with. And I always had in the back of my mind that, I will get over all of this, all these body issues and everything, when I'm really in love with someone it won't matter at all. And it was true to some degree. It mattered a little bit less, but it still mattered a lot. And so at that point I realized that I had to stop trying to forget about all of these gender issues that I had and start to re-look at them. And once I started re-looking at it, it was just like kind of floodgates opened, and I was just confronted with all of my desires that I had been trying to push away, of just feeling like I felt like a man. Like when I would have a perception of myself, like the quick kind of perception, of like just me in the world, I would see myself as a guy. And then I would have to force myself to not, and try and change that to fit myself being a woman in the world. And once I started realizing that, that I was still working so hard on that and I didn't want my whole life to be that way, I just started doing research. And when I saw Loren Cameron's book, and when I started reading articles about transsexual men, and seeing pictures I was like, oh, this is something that I really *can* do. I won't look like a freak. I mean, that was a big concern. Like, is this even possible, and that I'd have a happy life like that? And so once I started seeing that stuff, it opened up the doorway for that. But I still waited. I still waited until I was 24, to actually take hormones. And during that time, it was me trying to figure out, there's so many different things that I was weighing all the time. Ultimately I knew that I would probably go that route, but I was trying to see how long I could wait [it] out. I was trying to figure out if there was some other way to do it where I could feel comfortable. Like, if I could just be mentally strong enough and identify as a man. And I just tried all kinds of different things internally and externally to see if that would work, if that would make me feel good. And then, eventually I just came down to a place where I was like, I think that I'm ready to do this. And yeah, so I took some time and talked to a lot of people.

Like Leroy's experience illustrates, the transmen in the sample took time to carefully research the process and learned about their options for transition-related procedures. They knew that medical transition represented a serious life step. It is rarely the case

when a transman suddenly realizes he is trans and immediately enters into the health care system in order to actualize his desires. While some people—both transgender and nontransgender—worry that transitioning has become trendy, inspiring hasty decisions particularly among youth, this research did not reflect that cultural anxiety and other research confirms the finding that adopting a transsexual identity "is not an overnight event" (Bolin 1988:52).

Striving for self-actualization sometimes involved considerable emotional and psychological distress for the transmen in this study. Grappling with depression prior to transitioning was fairly common in this sample, as Trevor explained:

> God, life was just getting, *really, really* bad. Some of it had to do with the fact that I was in a relationship with a guy who I was of course out to as trans. But it was kinda like a tricky thing maneuvering around it. And he identified as straight with a queer/trans partner. So it was something that we were always talking about, and he was really supportive in a lot of ways. In a lot of other ways, like looking back on it now I can see how I kinda felt stunted, I guess. And so, when we broke up, it's not until looking back on it, and you can kinda figure out what was going on. But I think after we broke up, I felt a certain relief in that regard. Of like, you know this situation *sucks*, but okay, now I can start thinking seriously about getting access to testosterone. And from there, it was really like life got shittier and shittier and shittier. I can't even tell you how awful it was. It was just like 24/7 on my mind. And one night, I knew that I had to have a therapist letter, and one night just on a whim, I found two therapists and I just emailed them. And for my three months waiting period to get my letter, it was the only thing I could think about…. And I actually found a quote online that really summed it up for me. And it was in regards to someone's transition. It said you'll know when to go forward when the next step is as hard as remaining in this place. Or something like that. And that's really what it was like for me. It just became, it was *as* hard to start the process as it was to remain where I was. And it was actually easier to start my transition than it was to be living my life that.

Similarly, Nate agonized over transition, "Basically, it was a *last resort*. In fact, *transitioning* was a last resort. It's like, how long can I live this way? Without doing anything? And eventually it just got to be *unbearable*, so I saw it as like a last resort intervention." Transition also became a life-or-death issue for M&M, who explained,

"Ultimately, I just couldn't take it anymore. I was at a state where, I just had to. I had to. I felt like I would die." Reflecting on how outsiders perceive the decision to transition, Sam explained, "People think that it's such a brave thing to do this, but it's brave to live up until that point." Sam's differentiation between bravery before and after transition demonstrates the turmoil that many of the transmen in this sample endured prior to starting transition.

However, a few men in the sample described their paths as more evolutionary, without prolonged misery. Although Adam's path toward becoming a transman appeared atypical, his process of self-actualization still involved serious consideration:

> I definitely did not grow up feeling quote-unquote "in the wrong body," which is sort of what I think of as sort of the standard transsexual narrative or the traditional trans narrative. I was a feminine child. I was the only female child in my family after two boys. So my mother was so delighted to have a girl that she dressed me in pink and dresses and flowers and ruffles from basically the minute I was born. Which was really not problematic for me because you know, I sort of enjoyed the whole dress-up aspect of it, throughout childhood. And I continued to have a very feminine gender expression all through high school, and even into the beginning of college. But at the same time, as I got older, felt less at ease, I guess? With my, and I don't know a better way to say it than just in my body. Just not really a whole person in some ways. But I didn't connect that to gender, really, for a while. And I also don't feel like it dawned on me one day that I was trans, sort of the equivalent to oh I finally opened this door in my mind and there was this trans identity just fully formed and waiting for me to recognize it. That also was not how it felt for me. But I came out as queer to myself at the end of high school, and then openly when I got to college, which felt very right. That felt like the right identity somehow. It sort of clicked into place. But I still couldn't figure out, I wasn't quite there because, I wasn't really particularly attracted to women. When push came to shove, I didn't really want to have sex with them. So I was sort of trying to figure, and I knew I wasn't butch. And then, it was sort of becoming increasingly clear to me that I wasn't a femme dyke. So it was very, I couldn't make all the pieces fit together. But over time, really through college, as I met more people and talked to more people and started to hear about, started to read Leslie Feinberg's books and hear about people who identified as trans and what that could mean in different ways. I feel like I sort of grew into a trans identity. Like it evolved as something that was the right answer for me. So I guess that's a long-winded way to say that being trans, my identity, the evolution of my

> identity led me to being trans. It's not like trans was something that came first that then determined my identity, if that makes any sense.

In Adam's experience, his evolving identity paved his way to transition when other available identities did not quite fit. Still, this process allowed him to interact with information about transition along the way.

Ultimately, the transmen in this sample realized that entering into medical transition was in essence a decision from which they could not retreat. They viewed starting hormones as representing the beginning of a permanent change. Although some changes from testosterone are reversible, such as increased muscle mass, others are irreversible, such as deepening of voice (Gorton, Buth, and Spade 2005). Before starting T, John described the experience of starting hormones as "this feeling that there wasn't any gray area. You couldn't go on a low-dose and go off, or go on for a while and stop. It was like, either you're on hormones, and you turn into some total man, or you're not." The men in this sample started medical transition knowing that it represented an important commitment.

These narratives demonstrate the seriousness with which these men considered transition. As the above quotations illustrate, transition ignited a meaningful step toward realizing the potentialities of the self. Through changing their bodies, transmen could finally start to live their lives as they envisioned. Once they took this step, transmen thoroughly researched the possibilities available to them. Transition was so vital and so necessary that they needed to learn as much about their available options as possible. Their long processes of self-actualization motivated these men. In this way, transmen spent a lot of time interacting within transgender networks of information where they

received different messages about medical transition. Through these networks, they became informed consumers prior to entering into health care systems.

NETWORK OF INFORMATION

Transmen in this sample utilized a variety of resources in researching transition. Most of them described using the internet to learn about transition. They accessed websites geared toward providing resources for transmen, like Transster.com, TheTransitionalMale.com, and AmBoyz.org[10]. These websites contain detailed information about different aspects of transition, including photo galleries and surgeon reviews such as, "Love it! Occassional but slight twinges of pain. Sensation in all skin except nips so far. May revise dogears eventually. Loved Brownstein!!!! [sic]"[11] Their bountiful resources enabled transmen to learn about the steps of transition, their side effects, possible health risks, and any relevant authorization requirements. Transmen in this study also visited personal websites of FTMs who posted detailed accounts of their experiences with transition. For nearly all of the men in this study, the internet provided an invaluable way for them to process information and network with other transmen.[12] Even men who lived in more isolated or rural communities accessed the internet before entering into medical transition, although these transmen tended to rely on their health providers for further resources. While the internet offers similar resources for other

[10] The American Boyz website is no longer active.
[11] This review comments on a chest surgery obtained from Dr. Michael Brownstein and accompanies photographs of a chest before and after the procedure. I obtained the review from a website requiring private membership, so to protect the users' anonymity, no reference is provided.
[12] Since data collection methods heavily relied on contacting respondents via the internet, this individual finding represents a bias of this particular sample. However, since the internet represented only one aspect of the entire network of information, I believe this bias only minimally affects the general findings of this study.

consumers of plastic surgeries,[13] transmen are unique in that they navigate this network of information mindful that obtaining these procedures requires outside authentication.

In addition to the internet, the men in this sample researched transition through other means. Many of the men encountered Loren Cameron's book *Body Alchemy*: *Transsexual Portraits*, which artfully portrays the posttransition bodies of transmen. Others reported reading books about FTMs in medical and academic literature. Some of them saw the film *Southern Comfort*, which chronicled the life of Robert Eads, a transman who died due to scores of providers refusing to treat his ovarian cancer. Others described viewing documentaries about transsexuals on cable television.

Meeting other transmen was by far the most helpful aid in deciding to transition to the majority of transmen in this sample. They described meeting other transmen in transgender workshops, support groups, and conferences. Some of them knew other transmen from their involvement with the transgender community, and so identified people with whom they could discuss these issues. By interacting with other transmen in person and in transgender contexts, the men in this sample were able to engage men directly about their experiences with transition. Men described these encounters as more personable, even expressing that live messengers were somehow more reliable. As Joey explained, meeting men at the transgender conference True Spirit[14] helped him tremendously in his decision to start hormones after getting chest surgery:

> Then a month later I went to True Spirit, and that really kind of solidified it for me. You know, just kind of seeing how I felt. I had been to True Spirit the year before, talking to other people, because talking to other people allowed me to

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[13] For comparative and illuminating examples of community and personal websites dedicated to nontransgender plastic surgery, see www.implantforum.com, www.allaboutlipo.com, www.beautysurg.com, www.obesityhelp.com, http://health.groups.yahoo.com/group/CosmeticSurgerySupport/, http://myliposuction.tripod.com.

[14] The True Spirit Conference no longer convenes.

> weigh the risk and the benefits in a more real way. Not just these random stories you hear on the internet, not like just uninformed people, but talking *to* people and understanding that it wasn't gonna be magic, but nor was it gonna be like a disaster. And there were risks and benefits and I had to weigh it out. So at that point, after having my chest surgery and after being able to really interact with people who had been on hormones, that was what helped me in my decision.

M&M started transition prior to the information age, so meeting a transman in person was almost magical:

> Back then, it would be hard to find someone, especially a female-to-male. Jimmy was like a living, oh my god, when I saw him for the first time, I talked to him on the phone, and to actually see him with my eyes, it was almost like Santa Claus. It was like oh my, he was every step, was like, it is *real* and I can actually *be* this and *do* this. So it was almost like, just how do I go about doing it.

Seeing another transman in person "just meant possibilities" to M&M, who was so mystified by the experience that he thought of testosterone as a "miracle drug." Through these interactions, transmen connected to an extensive network of information that provided them with plentiful information about transition.

Getting involved with transgender networks of information allowed men to carefully research transition. These networks provided transmen in this sample with ample information to prepare them for their encounters with health providers who would likely consider their desired for hormones and surgery as indicative of mental illness. In my research, I found that transmen encountered four main types of messages about transition within these networks. The messages centered around the technicalities of transition, reputations of health providers, horror stories about health care, and the process of psychomedical gatekeeping. While messages like these emerge constantly within transgender communities, transmen in this study actively solicited and interpreted these messages before starting transition and during the early stages of transition. This information was timely and especially relevant since they were about to enter into

transition themselves. They also returned to these messages before accessing specific transgender services for the first time (e.g., chest surgery), new providers, or unfamiliar health care sites. In other words, transmen concertedly accessed the transgender network of information while planning for a new experience related to transition or for accessing health care as a transman. Within these networks, transmen confronted different messages relevant to transition and transgender health care in general that affected their interactions with health providers. This preparation enabled transmen to become informed consumers, which proved important in equipping them with the knowledge needed to successfully negotiate health care systems and anticipate obstacles to treatment. The next section details these messages, concluding with their relevance to the process of becoming informed consumers.

MESSAGES—TECHNICALITIES OF TRANSITION

A primary message transmen in this sample encountered within the network of information detailed the technicalities of transition. In researching transition, transmen learned about the technicalities of testosterone and surgery, and their associated side effects and potential health risks. They received a range of information that allowed for different interpretations. Some men evaluated the advantages and disadvantages of starting hormones. Others perceived the information on risks to be inconclusive. A few equated their risks to be equal to cisgender, or nontransgender, men.

Since all of the men in this sample were on testosterone, the benefits of hormones outweighed any risks they perceived. SpiritTrans described some of the side effects and health risks he heard about testosterone before starting it himself:

> I had heard a lot of stuff, yeah, before I started myself.
> **Elroi: What kinds of things?**
> Well, good things and bad things. [laughs] I think, good things you know because it was always said, and I've experienced that, that it increases your sex drive. And it changes your body structure to a certain extent. Bad things, basically some people and many of us, we go through depression sometimes. We go through a lot of what we call "roid rage." You know you get kinda, like being manic depressive actually [laughs] bipolar or something. You're kinda like flippin' out, you know both ways. So it was kinda scary at first to hear about it, but I think the good stuff outweighed the bad stuff. You know, the hair growth, and the facial hair growth, and the body structure changing, your voice changing. All that stuff kinda outweighed the negative stuff. I mean there was some health concern, the health concerns about testosterone, the effects it'd have on your liver and stuff like that. But I think for most of us, the good things outweigh the bad things.

Even though SpiritTrans perceived these risks as real possibilities, he still downplayed the negative aspects of hormones. He believed that transmen took the risk of starting T because they preferred its effects. Dave's interpretation of the technicalities of transition certainly confirmed SpiritTrans' speculation that living on testosterone would be better despite any health risks:

> Before I started taking it, it was all the pros and the cons. Everybody said you're too old to do this. You're going to have liver problems, you're gonna have heart problems, you're going to stroke, you're going to die. And it didn't matter. I'd never seen one thing on any printout or anything that I heard from anybody that was worse than what I was already livin' in. So it's worth the risk, to be able to be who I am and what I am. So anything that I read about it wasn't bad enough to stop it. Just go for the gold. [laughs]

Evaluating health risks of hormones was common among the sample. For transmen like SpiritTrans and Dave, changing their bodies to fit what they envisioned was worth any foreseeable risk in transitioning. Hormone risks were negligible, as long as they could live their lives as self-actualized transmen.

While some men interpreted messages about transition technicalities as risks and benefits that needed to be assessed, others expressed ambivalence about the dangers of

transitioning. Zed reported hearing nebulous information concerning the technicalities of transition, which he ultimately dismissed as unconvincing:

> So what I heard about testosterone was not a whole lot. I couldn't find out any concrete information on what the health risks are and I would really challenge anyone currently who thinks they know what those health risks are, 'cause I don't think any of us know. [laughs] I'm very interested in studies and what we're finding out and compiling long-term decades and lifetimes worth of tracking people's personal health. But you know, we've not been doing that because it's so new. And also because so many of us disappear once we transition.... So yeah, but I had definitely heard about ovarian cancer as a risk. So I guess that's most of the stuff about T that I heard. And I also heard like the whole like are you going to turn into this aggressive asshole [laughs] thing, that was propaganda that I heard.

Zed's interpretation was fairly typical because transmen in this sample frequently encountered conflicting and inconclusive messages about testosterone. Some men in this sample worried about the lack of definitive information, but transitioned anyway. They desired more research about the long-term effects of T, but were still willing to take the risk. For these men, the messages they heard were not persuasive enough to prevent them from transitioning in the manner they wanted.

While most transmen in this study interpreted risks—whether real or unfounded—as unambiguous disadvantages, others perceived the risks of starting testosterone as signifiers of maleness. These transmen viewed the potential health risks as comparable to health risks for cisgender men. They interpreted the consequences of testosterone in transmen as similar to the way testosterone functions in genetic males, or "bio-men." Solomon explained what he heard, "And the things you heard was yeah, it's hard on your liver. Yeah, it'll make you prone to heart attack. Blah, blah, blah. You can't smoke and take testosterone. Like well, what's the difference between me and a bio-boy who smokes? We've both got testosterone." Micah also recognized that starting testosterone would put him into similar unavoidable health risk brackets as other men, particularly

with risks of heart disease, “I just understood that and understand that as just raising my risk to the risk of other men. I mean, that’s just the way it goes [laughs].” Accurate or not, this reasoning suggests that some transmen considered health risks that are common among men as additional signifiers of maleness. If starting testosterone made transmen more prone to heart disease, then this health risk might also confirm maleness, and thus would be less problematic in considering transition.

As these quotations illustrate, conflicting messages and lack of information about the risks of testosterone represented some concern as men in this sample considered transition. Since they all transitioned, the benefits of doing so clearly surpassed the risks. Overall, these transmen went through a process of evaluating the seriousness, credibility, and integrity of risks associated with transition, ultimately concluding that transition was right for them.

By receiving and interpreting these messages, transmen became informed consumers in that they knew what treatments would do for them. They knew the masculinizing effects of hormones and the potential risks testosterone could have on the body. This information was important because transmen often interacted with experts in the field—endocrinologists, physicians, and surgeons. Yet through their transgender networks of information, they became something like experts themselves. Well versed in transition services and effects, they frequently reported that they knew just about as much as their providers, and even more in some cases.

MESSAGES—REPUTATIONS OF HEALTH PROVIDERS

A second prevailing message about transition concerned the reputations of health care providers. Within their networks of information, most of the transmen in this sample reported hearing specific messages about the reputations of different health providers that offered transition services. The messages related to the skills, costs, and demeanors of providers. Like hearing about the technicalities of transition, messages about health provider reputations allowed transmen to carefully evaluate different providers. This information enabled them to choose skilled providers with experience treating transgender people who would permit treatment with minimal or no resistance.

While transmen disseminated information about general practitioners throughout these networks, many of these messages pertained to information about different surgeons who performed transition-related procedures. Adam explained the process of hearing about the reputations of chest surgeons:

> Having not had surgery for so long but having been in the trans community, I had heard many, many people talk about many different surgeons. And so I had a sense by the time I started thinking about it for myself. I had a sense of who the most reputable providers were, and which results people were happiest with. And also, I had seen a lot of examples of guys' chests from different surgeons, just through friends and through people I've dated. So, I wasn't sure whether I was small enough to have keyhole surgery, so just from word of mouth, it seemed to me like the two best surgeons, and from results that I had seen, were Brownstein for double-incision, and Fisher in Maryland for keyhole. And then, I spent some time, I went on to Transster, the website, and spent hours looking through the different pictures of results and the best was when guys had before pictures up there so I could compare their size to mine and see what the results looked like.... And then in September of last year, I went to the FTM 2005 conference in Seattle. And [Brownstein] was there, and he did a workshop; he does this slideshow. I think I might have even seen once before, or maybe that was the first time? But he goes to conferences and makes presentations about his work. And so he was there and then after his workshop, I stayed afterwards and met him in person and showed him my chest and he basically confirmed that he could operate on me. And so shortly after that is when I called his office and set up the appointment.

Adam's process of finding a surgeon is fairly typical. Transmen in this sample often thoroughly researched surgeons prior to consulting with them. Nate explained what he heard about his chest surgeon, "He was friendly, and he has a great reputation in the trans community. And I had heard such good things about him, and that was certainly true when I met him." Communication about the reputations of providers circulated throughout transmen's networks of information.

Messages about health providers' reputations allowed these transmen to research their options. They learned who performed quality work, and who treated patients with respect and care. Like information about transition technicalities, messages about reputations enabled transmen to make even more informed decisions regarding their health care. These messages aided in their process of becoming informed consumers. Logically, not one of the respondents reported going to a provider that had a horrible reputation. While they sometimes accessed care with providers who were regarded as mediocre, they entered into those situations expecting as much. However, in some cases, the great reputations of revered providers led to heightened expectations. And when these expectations were not met, the experience disappointed a few men in the sample. John explained this experience after having a bad experience with Dr. Michael Brownstein, a chest surgeon widely regarded among transmen as the most esteemed, and the same surgeon referenced previously by Nate:

> And it was really really weird, because he's a doctor that is probably one of the most popular top surgeons, and everyone is like, "Ohhh." And in terms of like, my chest looks great. Like I'm really happy with it. And it wasn't until after that happened when I started talking to people about, I was like, well, he's a good surgeon, but I also think he has a really horrible bedside manner. I think he's really unprofessional. That was when I started to hear other people's stories. Because it was like, I feel like a lot of people feel the need to defend their surgeon, or like talk them up. And especially with Brownstein, who's who I went

> to. Everyone's like you know, "Brownstein's a god! He is so great," blah, blah, blah.

Although this popular chest surgeon was touted throughout the transmen's community as doing excellent work, his effectiveness as a provider suffered due to his curt demeanor. And when John relayed his dissatisfaction with this treatment, only then did he hear others concede that this surgeon indeed had flaws. For John, more nuanced messages about this health provider's reputation arrived too late. His experience illustrates ways that transmen sometimes minimized negative aspects of otherwise trans-positive health care providers, an experience that I will elucidate later when discussing psychomedical gatekeeping. Indeed, some men in this sample admitted that they would be willing to sacrifice friendly service when excellent surgery results seemed likely and warranted only short-term attention.

Transmen shared information about providers with other members of the trans community. In this way, they maintained reciprocal roles in the network of information. Hearing about the reputations of health providers afforded men in this sample the opportunity to carefully consider their available options and make informed decisions about their health care. They used this information in accessing both general and trans-specific care. Frequently, they entered the offices of health providers knowing about their demeanors, skills, professionalism, and transgender sensitivity. This information was useful in becoming informed consumers because transmen in this sample could choose providers that best suited their needs. If they preferred quality service with trans-friendly providers, they were more likely to endure bureaucratic hurdles. If they resented psychomedical gatekeeping, they sought providers who minimized authentication,

sometimes sacrificing quality of care. The ways that health provider reputations affected interactions with health providers will be explored more in depth in the next chapter.

MESSAGES—HEALTH CARE HORROR STORIES

One powerful message concerning transition relayed different health care horror stories circulating through the transgender community. Many of the respondents in this study reported hearing awful stories related to transgender people's experiences with health care. These horror stories included high profile cases of mistreatment, situations that threatened people's abilities to maintain coverage for health care, and negative encounters with providers perceived as pervasive. They affected the ways transmen prepared to enter into new or unfamiliar health care situations. Transmen learned that they needed to be cautious within health care systems.

One type of horror story that disseminated throughout the trans community concerned high profile instances that received national press. For example, Joey heard specific horror stories about the health care experiences of a famous transgender activist and author, as well as an incident that garnered national attention:

> I remember the Leslie Feinberg stories, really about Leslie Feinberg going to the emergency room and being really mistreated, and not being treated, and having to leave, and not having access to medical care. And about a transwoman who was left for dead on the side of the road outside of Washington, D.C., after she was in a car accident and the paramedics stopped performing CPR on her.

Similarly, Sam reported hearing about the case of Robert Eads, an FTM who died from ovarian cancer that doctors refused to treat:

> I had heard that some people just were turned down for some health care. I mean, now we're talkin' about heresy and anecdotal stuff and I can't put my finger on any of it, so I don't know how valuable it is, but I mean, we know about the Robert Eads story. We know it happened to him. He lived in North Georgia.

Andrew also heard the horror stories from a family member, “We all hear the horror stories. And of course my mom will watch HBO and see specials and she’s freaking out. ‘You’re gonna die if you get cancer.’” Hearing about incidences like these affected transgender people’s perceptions of what they could expect when accessing health care.

Another type of horror story concerned instances of providers outing people as trans to health insurance companies. Micah heard about not getting insurance coverage for basic services if you are outed as trans to your health insurance company:

> I went to get GYN care once, which I had to go to the women’s health center for. Which was like, that was great [sarcastic]. [laughs] So I was really nervous that they were going to tell my insurance company that I was trans because I heard all these horror stories about not being able to get coverage for *anything*, even like strep throat if you are out as trans to your health insurance company.

Through messages like these, transmen worried not only about being treated poorly by insensitive providers, but also about losing coverage from insurance companies that typically refuse to cover transgender-related care.

Most of the horror stories relayed by respondents in this study concerned instances when providers mistreated transgender people. Transmen in this sample reported hearing about poor treatment, including stories of abuse in health care systems. SpiritTrans had heard about providers expressing repulsion upon encountering a transgender person in the examination room, which contributed to his apprehension about accessing care:

> I heard, it’s difficult, like it’s just difficult going to the doctor. Because you’re sitting in there and if you’re a transman, you still gotta go to the GYN or whatever and you’re like the only man sitting in an office full of women.... I heard a whole bunch of experiences..., about how the receptionists treat you. And then once you get *in* with the doctor, how they kinda like, some of ‘em will give you like a look of shock or they don’t know how to deal with the whole situation so they just react to you very incorrectly if your insurance card has your female name on it,

> they seem to continue to call you Miss, and stuff like that or whatever. And they don't want to hear what you have to say as far as how you wanna be identified or anything. And it's just a lot of uncomfortableness that goes into it.

In SpiritTrans' case, he heard numerous horror stories from other trans people he encountered in support groups he joined when starting transition. These horror stories provoked anxiety within many of the respondents around accessing health care services.

Horror stories about providers mistreating transgender people generated especially strong fears of emergency rooms among some of these participants. As Zed made clear, "I just think that would be fucking a nightmare." To prepare for an emergency situation, Zed's wallet contained a special card with pertinent information that he believed would be useful if he needed emergency treatment while unconscious. Accessing emergency services typically put transmen in contact with health professionals that they did not know. Distrust and guarded communication with unfamiliar providers is common among anyone (Lang 2000). However, accessing the emergency room as a transgender person represents additional worries, as transpeople report encountering discrimination in health care experiences (Lombardi 2001). As Drew explained, "I think that while nobody really wants to go to an ER or receiving emergency care in any area, I think that being trans has a heightened anxiety for me." Transgender status may become known when transmen reveal they take testosterone or when they disrobe for medical examinations. Additionally, medical records may exhibit incongruent name and sex designations.

Transmen in this sample typically struggled with coming out as trans in these contexts, and worried about how they would be perceived by providers if their transsexual status became known. While transmen expressed anxiety about encountering

transphobia among providers, they also worried about becoming a spectacle for the staff. Fearing being put on display, Dave reasoned why he was not looking forward to accessing the emergency room:

> I know what's gonna happen. I know how I'm gonna be treated. You're gonna be put on display. The minute that number one finds out, you'll have people comin' by that room for no reason at all, if they're comin' in to pick up a band-aid, they're gonna come in that room. Because you're on display. Because I gotta see what this looks like.... The majority of my friends that I know work in the medical field.... And all these people tell you about things that come through the ER. And they have all said, every one of them, when you have to go to the ER, you're going to be put on display.... So I try really hard not to have to go to the ER. And I really don't want to have to go to the hospital if I don't have to, because I know it's comin.'

Dave's explanation for fearing the ER illustrates how powerful these horror stories can become. Even after surviving a horrible experience in an emergency room, Joey explained, "I was grateful that I was awake and able to advocate for myself, because honestly this is just such a trans cliché, but I just can't think of anything more scary than having to go to the emergency room and not having anybody there with me, and just having them discover on their own that I'm trans by having to take my clothes off."

The horror stories that circulated throughout transmen's networks of information contributed to anxieties in accessing health care. Whereas messages about transition technicalities and health provider reputations aided transmen in accessing trans-friendly and quality care, these horror stories represented overtly negative messages about health care and ignited more fear around health care systems in general. Like the process of evaluating health risks in starting transition, hearing detailed horror stories still did not represent a great enough barrier to prevent these men from becoming transsexual men. But it did increase anxiety in accessing health care generally among most of the transmen

in this sample. Becoming informed consumers thus entailed learning that one needed to be somewhat on guard when accessing unfamiliar providers.

MESSAGES—PSYCHOMEDICAL GATEKEEPING

Messages about the process of psychomedical gatekeeping represented a key finding of this research. Within their networks of information, transmen encountered messages about barriers in accessing transgender-related services due to guarding by medical and mental health professionals. Based on this research and a thorough review of available literature, I have defined psychomedical gatekeeping as the systematic process of withholding or conferring services based on a transgender person's compliance with psychotherapeutic, medical, endocrinal, and surgical regimens and credible gender performance.

Transmen in this sample reported hearing about providers who functioned as gatekeepers to individuals' transitions. Typical gatekeeping messages included instances when providers refused or delayed testosterone and surgeries, and encouraged conventional masculine behaviors to ensure approval for transgender services. Generally, messages about psychomedical gatekeeping fell into three main categories. Transmen learned about therapy protocol for authorizing transition. They also learned that doctors could deny transition services if a transgender person refused to follow medical protocol or had a health condition that precluded treatment. And finally, they heard about potentially needing to relay appropriate gender narratives accompanied by hegemonic gender presentations to psychomedical providers to ensure transition approval and

delivery of services. These messages resulted in preparing transmen for dealing with hurdles that could have prevented them from transitioning.

Psychomedical Gatekeeping Messages—Therapy Protocol for Authorizing Transition

Before starting transition, nearly all transmen in this sample reported familiarity with the protocol they would be expected to follow in order to secure the services that would give them the bodies they desired. Minimally, most of the men in this sample reported knowing about the *Harry Benjamin Standards of Care*.[15] When dealing with transgender people, providers largely adhere to these guidelines since diagnoses of mental disorders or counseling around gender issues typically constitute a prerequisite for transition. The diagnoses of Gender Identity Disorder in the *Diagnostic and Statistical Manual (DSM-IV-TR)* and Transsexualism and other Gender Identity Disorders in the *International Statistical Classification of Diseases and Related Health Problems (ICD-10)* classify transgender experiences as mental disorders (American Psychiatric Association 2000; World Health Organization 2004). The *Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders* (Meyer et al. 2001) guide providers in assessing potential candidates for transition procedures. Counselors, physicians, and surgeons each bear ethical and legal responsibilities in authorizing transition (Meyer et al. 2001).

The Benjamin Standards describe guidelines that, when analyzed closely, offer vague and even conflicting protocol requirements for people seeking transition. These incongruencies and ambiguities will be exposed in the following chapter when I detail the

[15] Chapter 4 examines these *Standards of Care* more thoroughly. Readers should note that the standards do not simply enumerate eligibility criteria, but provide relevant historical, epidemiological, and procedural information in a 22-page manual.

ways providers enact gatekeeping measures. However, information about the Benjamin Standards proliferates throughout transgender networks of information. Through these networks, transmen understood that therapy represented the first step they needed to take in starting transition. And before men in this sample even stepped into providers' offices, they had heard about what could potentially happen.

Due to the way psychomedical institutions pathologize transsexualism, transmen usually must obtain letters from therapists authenticating their decisions to change their bodies to reflect their desired genders. The Benjamin Standards suggest that mental health professionals provide written documentation to physicians and surgeons (Meyer et al. 2001). Transmen in this sample reported familiarity with this therapy process. Zack explained that accessing the transgender network of information provided him with basic information and put him in touch with providers that then gave him further resources, "I had done internet searches, and that's where I became familiar with the Harry Benjamin *Standards of Care*." Even though Adam said he was only vaguely familiar with the *Standards of Care*, he knew that therapy was required in the process of transitioning:

> I don't think I really understood very much about the *Standards of Care*. I hadn't read them. I guess maybe I sort of did understand on a very basic level that you were supposed to, or a lot of people did see a therapist before they were allowed to start on hormones, or before they chose to start on hormones.

Zed knew exactly what he needed to do, and utilized the obligatory therapy efficiently in order to start medical transition as quickly as possible:

> I mean, doing therapy was part of my getting ready. I knew I was gonna have to do it because of the Benjamin Standards. So I was doing it because I knew I would be needing all of that stuff. So, I did exactly three months of therapy and got my letter for hormones and went to the doctor and got my hormones and had surgery.

The ways that these three men described understanding the therapy process was common among the sample. Before transmen accessed transition, they knew they had to first see some type of counselor before they could obtain hormones or surgery.

However, classifying transgender experiences and expression as mental disorders and imposing psychomedical gatekeeping represents a controversial issue in transgender and professional communities. Some men reported knowing that therapy requirements and medical gatekeeping represented a contentious issue. Before accessing counseling, Kevin described knowing about the different ways that transmen viewed psychomedical gatekeeping:

> I mean there's the whole gatekeeper attitude that you hear a lot of people saying that you have to go through counseling just so you can do all this stuff, and they're pretty resentful about that process. Other people say that it was really helpful, that it's something that you probably should do because it's such a dramatic change. I think, of pretty much the gamut of people being very resentful about therapy, to people who don't care, to people who are really supportive about it. There's big political issues over the whole gatekeeper idea.

Drew believed therapy assisted people in their life struggles. But he also felt that therapy entailed a lot of vulnerability, and expressed apprehension about therapists abusing their gatekeeping power because it had happened to people he knew:

> It's a scary process because you're always making yourself vulnerable. And even when somebody has seen other trans folks or deals with queer people, you don't know if their opinion of it is gonna influence you. And they're so important, we have to get our letter from them. So there is kind of a gatekeeper mentality idea. I know a handful of guys who started seeing a therapist not so much to explore whether or not they were gonna start the transitioning process, but almost more because they knew that it was a necessary step, because they have to get this golden ticket—their letter. And I think that those experiences are just terrible. You're not there for yourself. You're there for a purpose. You have to see this person for six months before you actually get your letter. Some therapists will lie, some won't. Some guys are all about getting their therapists to lie, some aren't. Some are there to try to answer a way they think their therapist wants them to, just this whole idea that like you're not gonna make a mistake and risk getting your letter.... Playing off of that in a therapy setting is really dangerous. But I know a

> lot of guys who do it, and I've known a handful of guys who have been told "no" for their letter. And I think for anybody, going and sitting down with a therapist and being willing to be vulnerable, takes a lot to have somebody not respect that. And for someone to abuse the power of like, I'm not gonna let you transition. I mean that's, that's like your greatest fear.

Clearly, some men in this sample knew that members of the transgender community felt suspicious about therapy requirements. Although they may have entered therapy ambivalently,[16] this information made them conscious of gatekeeping. They knew that they needed to go through therapy to get that "golden ticket" to be allowed access to hormones and surgery.

Therapy requirements unequivocally irked other men in this sample. These transmen resented psychomedical gatekeeping. Solomon viewed the therapy process as another barrier in a series of bureaucratic hurdles to get the body he desired:

> Well when I started thinking about it, it was like 1990. And New York, we had the Gender Identity Project[17]. But the problem was, more than anything else, the bureaucratic hurdles. You know, you had to go through the psych evaluations, you had to get the referral, you had to do this and that, and *then* you had to find a doctor that *would* treat you.

M&M, an Afro-Caribbean man, described why he thought the therapy requirement for transitioning was ridiculous, "Of course I probably, by that time read the Harry Benjamin thing of, I knew I had to. I hated it, I can tell you that much. I was almost like, it's like going to counseling for you to tell me that I'm black. That's just how I felt about it. Like, I have to go through this thing to be validated in this experience." Dave also felt that being required to go to therapy was silly, and explained, "I wasn't really wild about

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[16] While many men ultimately viewed therapy as beneficial, the focus of this chapter is on the messages received prior to entering transition and how they prepared transmen for entering into health systems. I will explore posttransition responses to therapy in the final chapter of research findings.

[17] The Gender Identity Project is a program of the New York City Center for Lesbian, Gay, Bisexual, and Transgender Community Center devoted to transgender empowerment and social support. The program also offers counseling services for people dealing with gender issues.

going. I thought, God, go to therapy? I'm not crazy!" These guys thought it was absurd to go to therapy to get validated. Nate simply felt overwhelmed with the requirements:

> I think the first thing I ever found was the *Harry Benjamin Standards of Care* online. And it had all these crazy requirements. And I was like, oh my God! How am I ever going to meet those requirements? You have to have done this real-life test before you can get surgery. And then, you have to have 8 million letters, and blah, blah, blah. And months and months of counseling. So it was just, I had this huge barrier, and it just seemed really intimidating and scary.

While these guidelines are mere suggestions or possibilities for providers to impose, the threat that they could be required represented a powerful and intimidating message that some transmen resented. In their processes of becoming informed consumers, these men prepared for obstacles they might encounter in the offices of therapists.

Psychomedical Gatekeeping Messages—Medical Protocol in Conferring Transition

In addition to gatekeeping messages within therapy contexts, some of the men in the sample heard about medical protocol for administering hormones or performing surgeries. Gatekeeping messages in medical contexts included instances when transmen heard about how certain health conditions could preclude transition services, such as surgeons denying chest reconstruction to fat transmen. Other messages about medical gatekeeping included instances of excessive testing or comprehensive physicals prior to administering hormones. Most of the transmen who reported hearing about prohibitive medical protocol described messages concerning restrictions on hormone therapy. This was one of Andrew's worries:

> I wasn't nervous about going to the doctor. But it was just not knowing really what to expect as far as what they would say, if they would draw the blood before giving me a prescription, or if they'd draw the blood and test it and find out that I had some rare thing and wouldn't be able to take it. A thousand things go through your mind.

Learning about how health status might prevent him from accessing testosterone, Micah reported feeling nervous about being denied hormones for this reason as well. He attended a workshop that detailed health conditions that might prevent providers from administering testosterone:

> And like, you sort of sat there and you're like, oh my God! Testosterone's gonna kill us all! [laughter] We're gonna die in minutes! Like, it's all over! And I also thought it was really interesting 'cause I think that, from the questions that people were asking and also in my own mind, like what I was thinking about was, oh no, I'm going to get some complication and then they're not gonna let me take testosterone anymore! It wasn't like, oh my God, something's gonna happen and I'm gonna have a heart attack. It was like, oh no, I'm not going to be able to take testosterone anymore. Which is interesting.

Even when confronted with the possibility of serious health risks in taking testosterone, Micah was much more worried that he would have a health condition that would render him ineligible for hormone therapy. He feared that doctors might find something wrong with him and would then deny testosterone. For some transmen in this sample, the fear of medical gatekeeping was very powerful. Through becoming informed consumers, they learned that they would need to be in good health in order to obtain their desired bodies.

Psychomedical Gatekeeping Messages—Presenting Appropriate Gender

Messages about gatekeeping worried some men in this sample regarding how they would be expected to present themselves. The final psychomedical gatekeeping message transmen reported hearing related to the ways transmen told their stories and expressed their genders. Some transmen in this sample described hearing that they needed to relay

life histories that reflected a traditional transsexual narrative. Others heard that they needed to fit stereotypical models of masculinity in order to access transition services.

Messages like these prompted some transmen to feel anxious about their nonnormative gender expressions and sexualities. They worried about whether they would be seen as masculine enough for medical masculinization. Trevor felt highly conscious about the power dynamic his therapist held over him, and worried about his gender presentation, "I was really worried about being gay-identified, because I heard a lot of horror stories about people not getting letters because they weren't gonna make like a happy straight person. And still feeling a little genderqueer too, like not fitting the mold of masculine man." In addition to meeting and completing mental health requirements, Micah worried whether he would be seen as man enough or trans enough to procure the services he desired:

> I definitely knew before I ever sought transition-related health care, that there was this gatekeeper relationship with the trans community. And that people got turned down, weren't allowed to get hormones, weren't allowed to get surgeries, whatever. And so, before I ever tried it, I already had constant anxiety about whether I'm going to be seen as male enough or trans enough, or whatever. And also just like having a sense that, there's no real way to get around it.
> **Elroi: What do you mean? How would you get around it?**
> I mean, the only way around it would be to get hormones illegally or I guess, some substitute for hormones or whatever. Certainly at the time there would have been no way for me to do that when I first started transitioning, I just wouldn't have known how to go about it. Except I was looking at all the testosterone boosters and stuff online. But I was looking at that even before anyone had ever given me any trouble about getting testosterone. I had just heard so much about people getting turned down that I was always like, it could happen to me. They're going to find something wrong with me.

Micah understood that passing these requirements also meant performing a particular type of masculinity. He realized that he would have to present a credible identity of maleness in order to obtain the services that would make him pass as a man. In hearing

this type of gatekeeping message, some transmen felt fretful that they would not measure up to their providers' gendered expectations. Since they entered into these relationships hoping to gain approval for transgender services, such a concern provoked considerable anxiety among transmen with less typical transsexual identities. Some transmen worried that they would need to conceal their gender expressions and sexualities in order to appear like good candidates for transition services. Ultimately, a few men did obscure their identities during interactions with providers. For example, in meeting with a therapist to obtain a letter authorizing chest surgery, one transman neglected to mention his radical genderqueer past in order to appear more certain in his transition decisions. This strategy will be explored more thoroughly in the following chapter, which describes how transmen negotiated psychomedical institutions.

Psychomedical Gatekeeping Messages—Consequences

In becoming informed consumers, many transmen took messages about psychomedical gatekeeping very seriously. As a result, a few men tried to postpone medical transition, and pursued alternative means of feeling satisfied in their bodies. Based on different messages they heard concerning health risks and psychomedical gatekeeping, these transmen contemplated natural or illegal ways to procure masculine features. Such alternatives included using herbal testosterone boosters, purchasing illicit hormones, and striving to be mentally strong. While a few transmen perceived herbal methods as less dangerous than prescription testosterone, alternatives to medically-regulated transition also provided a way transmen might change their bodies without confronting gatekeeping measures. But for the men who considered these alternatives,

none were satisfying enough to prevent them from embarking on medical transition. These transmen wanted their bodies to reflect the changes that only prescription testosterone could afford.

More pertinent to this study, hearing messages about psychomedical gatekeeping also led some men to consider invoking the so-called "typical true transsexual narrative." The typical true transsexual narrative reflects the popular belief that all transsexuals have felt trapped in or were born into the wrong body at some point early in their lives (Meyerowitz 2002). Some of the respondents in this study were aware that relaying this narrative to providers could more easily secure transition-related services. Earlier, a quotation from Micah revealed his concern about passing as male or trans enough in order to present a credible masculinity. He explained that he would do whatever it took if it appeared like he was going to get turned down:

> And it was also sort of a thought process that I would absolutely be willing to lie, if it became necessary. I wouldn't have any problem with that.
> **Elroi: What would you lie about?**
> Like, if it were, something about like, there's this idea of this typical true transsexual narrative or something like that. I felt pretty well aware that I could produce that on demand. I didn't know that I was a boy from the age of two or whatever. That wasn't my experience. I figured it out later. But I would say that if I needed to to take testosterone. [laughs]

This quotation illustrates that Micah knew he could invoke this popular discourse if needed, even though it was not true for him. While Micah was the only respondent in the sample to talk about this narrative as a strategy he could use in response to messages about psychomedical gatekeeping, other transmen recounted interactions with providers where they considered or invoked the typical true transsexual narrative. The ways they negotiated this discourse will be discussed in a later chapter.

The transgender network of information prepared transmen in this sample for transition. While spending copious amounts of time considering and actively researching transition, transmen in this sample learned a great deal of information that would aid them once they decided to enter into the health care system to begin transition. Their networks of information provided them with details about what they could expect from hormones and surgeries. Subsequently, the networks also connected them to health care providers with great reputations in the transgender community, steering them from unsupportive providers. In these networks, transmen also learned about the horrible ways health care professionals had been known to treat—or mistreat—transgender patients. These horror stories seemed to keep many of these men on guard when entering into unfamiliar territory. And most importantly, transmen learned about the ways that health care providers approved and denied services to people who wanted to transition. Some researched alternatives to medical transition or prepared to invoke conventional transsexual narratives. Within these networks, transmen in this sample became highly informed consumers. They entered into health care systems equipped with conflicting information. These messages kept some men on guard. Some even felt fearful and trepidatious. Other transmen entered into these systems skeptically. A few tried to maintain positive attitudes. And still others just did what they needed to do in order to get the care they desired, even when that meant masking aspects of their lives.

These findings illustrate that transmen represented informed consumers who accessed medical transition with a great awareness of what to expect in interactions with providers. Through researching transition, they learned about the technicalities of transition, reputable and irreputable providers, horror stories of mistreatment, and

gatekeeping. Through this complex network of information, transmen encountered many different messages from questionably reliable sources. The messages were clear: it can be a struggle to transition and attain a desired gendered body. Men in this sample largely anticipated reactions from health care providers in seeking transition. Through researching within their networks of information, they deciphered these messages and became well-trained specialists in the services they were about to consume. They became familiar with the medical processes and necessary steps to obtain their idealized bodies.

The process of becoming informed consumers represents an important way that transmen negotiate their identities and desired bodies. Psychomedical institutions exert incredible power over defining these men's experiences and approving the paths they desperately seek to realize. However, transmen do not enter into these systems as powerless beings. By becoming informed consumers, transmen become aware of the normalizing discourse that accompanies diagnoses of disorders. They learn it, and react to it differently. Some men embrace it, while others wholeheartedly reject it.

Psychomedical institutions regulate what it means to be transsexual by conferring services within the organizing principles of the *Harry Benjamin Standards of Care*. However, transmen assert agency even within this confining discourse. For the most part, they cannot avoid psychomedical gatekeeping. But they can consciously and intentionally submit to this normalizing discourse to access resources. They can also manipulate it to suit their purposes in pursuit of their desired bodies. Transmen enter into psychomedical institutions knowing the symptoms and treatment protocols for their diagnoses. They enter into these systems armed with information and are ready to exact

faculty in getting the bodies they want. When I asked Kevin what he had heard about medical transition, he explained, “I think I pretty much heard everything. I’d been to Southern Comfort Conference a couple of times and True Spirit when they were still active.... I had researched everything by that time. When I walked into my therapist’s office, I’m like this is what I want [laughs].” Kevin knew exactly what he wanted when he initially accessed psychomedical institutions to transition. This experience was commonly shared among transmen in this sample.

The next chapter details the ways that becoming informed consumers influenced transmen’s responses to psychomedical gatekeeping that they actually encountered. It will demonstrate the ways transmen negotiated the confining discourses of pathology within health care systems. As such, the next chapter illustrates the dialectical relationship between transmen and their providers.

Chapter 4—Psychomedical Gatekeeping

> *When did you first know you were different?" the counselor at the L.A. Free Clinic asked. "Well," I said, "I knew I was poor and on welfare, and that was different from lots of kids at school, and I had a single mom, which was really uncommon there, and we weren't Christian, which is terribly noticeable in the South. Then later I knew I was a foster child, and in high school, I knew I was a feminist and that caused me all kinds of trouble, so I guess I always knew I was different." His facial expression tells me this isn't what he wanted to hear, but why should I engage this idea that my gender performance has been my most important difference in my life? It hasn't, and I can't separate it from the class, race, and parentage variables through which it was mediated. Does this mean I'm not real enough for surgery?* –Dean Spade (2006:319), on negotiating medical transition.

Through becoming informed consumers, transmen typically entered into psychomedical institutions prepared to deal with discourses that pathologize their identities and desires for different bodies. The organizing principles of the *Harry Benjamin Standards of Care* frame the ways health professionals regulate transsexual transitions. As such, this chapter examines these guidelines closely. This chapter also outlines the gatekeeping measures that psychomedical institutions imposed on transmen as they negotiated transition services. Data illustrate how transmen's transition decisions must operate within confining discourses of pathology. Transmen grappled with different gatekeeping practices of mental and medical health professionals, and endured additional barriers that exacerbated the effects of these gatekeeping conditions. Yet some transmen were able to pass through health care systems with absent or minimal withholding of transition services, consequently accentuating the futility of restrictive gatekeeping under specific circumstances. This ultimately revealed that confining discourses could be avoided under certain circumstances.

STANDARDIZING PARAMETERS FOR PSYCHOMEDICAL GATEKEEPING—THE HARRY BENJAMIN STANDARDS OF CARE

The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders (HBIGDA SOC) provide guidelines for mental and general health care providers in assisting their transgender clients. They outline ways transgender people may become eligible for medically regulated transition. These standards of care offer suggestions for the recommended care and treatment for people that mental health professionals deem to have some form of Gender Identity Disorder (GID). They are the primary tools used by health care providers who work with transgender people, although alternative models have emerged[18] (Lev 2004).

The most recent edition of these guidelines is the sixth version, published in 2001 by an 18-member committee of the Harry Benjamin International Gender Dysphoria Association.[19] In this version, the standards claim that "[t]he major purpose is to articulate this international organization's professional consensus about the psychiatric, psychological, medical, and surgical management of gender identity disorders" (Meyer et al. 2001:1). They avow that professionals "may use this document to understand the *parameters within which they may offer assistance*" to transgender people (emphasis added, Meyer et al. 2001:1). The "general goal" for transition-related procedures "is lasting personal comfort with the gendered self in order to maximize overall

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[18] For examples of unpopular, alternative standards of care, see the International Conference on Transgender Law and Employment Policy Health Care Standards (1993) available at http://www.transgendercare.com/guidance/resources/ictlep_soc.htm, and the Tom Waddell Health Center Protocols for Hormonal Reassignment of Gender (2001) available at http://www.dph.sf.ca.us/chn/HlthCtrs/HlthCtrDocs/TransGendprotocols.pdf.

[19] In 2006, the HBIGDA initiated a name change and now identifies as the World Professional Association for Transgender Health, or WPATH. Details on this change are unclear, but the formal announcement can be found on HBIGDA's website at http://www.hbigda.org/20061stAnnouncement.htm. In this thesis, I will continue to refer to the organization as HBIGDA, as this is the title they used during publication of the SOC.

psychological well-being and self-fulfillment" (Meyer et al. 2001:1). It is within the parameters of this confining discourse that many providers deliver services to transgender people. But despite their authoritarian tone and user popularity, the *Standards of Care* (SOC) do not necessarily stress mandatory protocol. Rather, they suggest flexible recommendations.

A close inspection of the SOC reveals that no fixed rules for treatment exist. In establishing eligibility for transition procedures, "[t]he SOC are intended to provide flexible directions" (Meyer et al. 2001:1). They allow for modification by individual health providers and programs due to a transgender patient's circumstances, learned skills of experienced providers, and for research purposes (Meyer et al. 2001). When these rather general exceptions occur, the SOC recommend that providers explain this deviation in treatment to the patient and maintain records for legal and research purposes (Meyer et al. 2001). For example, the SOC would prefer that therapists document an instance of authorizing medical transition during a client's first visit. While the SOC contend that "triadic therapy"—psychotherapy, hormone therapy, and surgery—dominates clinical approaches to treating GID, they acknowledge that "not all persons with gender identity disorders need or want" a "real-life experience" in their desired gender, hormonal therapy, and surgical interventions (Meyer et al. 2001:3). In addition, the HBIGDA acknowledges that cross-cultural gender expressions may produce varying social, behavioral, and spiritual interpretations (Meyer et al. 2001). The association recognizes that not all cultures deal with gender diversity identically. The SOC implicitly rely on the way most Western cultures pathologize and medicalize otherwise normal variations in human behavior.

Gender Identity Disorder is not universally accepted as unambiguously indicative of mental illness. Some trans-positive psychotherapists believe that experiencing gender distress is not the same as being mentally ill (e.g., Rachlin 2002; Raj 2002). Considering the questionable classification of gender identity disorders as mental disorders, the SOC do not take a formal stance. Rather, they remark that the available diagnostic manuals demarcate myriad disorders of varying degrees in classifying mental suffering. The SOC carefully dodge this highly contentious issue, and instead proclaim:

> The designation of gender identity disorders as mental disorders is not a license for stigmatization, or for the deprivation of gender patients' civil rights. The use of a formal diagnosis is often important in offering relief, providing health insurance coverage, and guiding research to provide more effective future treatments. (Meyer et al. 2001:6)

This evasive position enables the SOC to preserve authority in treating transsexual clients without taking a definitive stance on pathology. Despite this noncommittal stance, the SOC do outline how health professionals might establish eligibility among their transgender patients, specifying criteria for transition services.

According to the SOC, mental health professionals may provide a variety of services for transgender clients, including counseling clients and formally recommending them for transition services (Meyer et al. 2001). As mentioned in the preceding chapter, therapists, physicians, and surgeons share ethical and legal responsibilities in authorizing transition (Meyer et al. 2001). The SOC necessitate that therapists initiate this interdependent relationship by supplying letters of documentation to providers of medical transition. Yet the SOC state that "[p]sychotherapy is [n]ot an [a]bsolute [r]equirement for [t]riadic [t]herapy" and maintain that "[t]here is no required minimum number of psychotherapy sessions" before transition services can be authorized (Meyer et al.

2001:11). The SOC realize that requiring therapy prior to medical transition is unnecessary due to the different ways prospective patients deal with gender issues, the ways these requirements are viewed as barriers and therefore limit productive therapy, and because therapists can offer support long after patients begin transitioning (Meyer et al. 2001). Ultimately, the standards do assert that "psychotherapy can be very helpful in bringing about the discovery and maturational processes that enable self-comfort" (Meyer et al. 2001:11). And while therapy can benefit anyone struggling with personal issues, transgender people must traverse an exceptional process of evaluation and scrutiny by mental health professionals to pursue their desired bodies. Retaining Gender Identity Disorder within diagnostic manuals of mental illness renders the policing of trans bodies normative (Monro 2000).

Despite acknowledging that therapy is not always required or necessary for transgender people, the SOC do explicate eligibility criteria for hormones and surgery. For hormones, the SOC list three eligibility criteria. Persons seeking hormones must be at least 18 years old, have a clear understanding of the medical and social advantages and disadvantages of hormones, and either "[a] documented real-life experience of at least three months" or "[a] period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months)" (Meyer et al. 2001:13). While it is questionable whether a therapist untrained in endocrinology can adequately explain the risks and benefits of hormones, the last criterion clearly mandates a role for therapy in seeking medical transition. This criterion warrants closer inspection due to earlier claims in the SOC that dispute therapy as an

absolute prerequisite to medical transition and imposes no time limit on any counseling services.

The SOC impose a restriction on transgender people who desire hormone therapy. Transpeople must have documentation of living in their desired genders for at least three months or provide evidence of psychotherapy (Meyer et al. 2001). While the SOC do not specify what constitutes appropriate documentation, therapy is the implied procedure. It is unlikely that a transman can walk into an endocrinologist's office with a diary or journal from his past few months living as a man and offer that as acceptable documentation. Similarly, a transman likely cannot bring in a notarized letter from his partner stating his or her acceptance of the transman in a male role and describing how he has functioned as such in all aspects of his life. Indeed, my review of the literature and the experiences of transmen in this sample do not indicate that such measures have ever been attempted. Therefore, although the SOC insist that therapy is not always necessary for transitioning, the eligibility criteria for hormones plainly contradict this previous assertion. With such confusing guidelines, providers might logically err on the side of caution in prescribing hormones and ask that transgender patients provide proof of therapy. Therapy prerequisites in accessing hormones, especially concerning documentation of counseling, prevail within research on this issue.

Overall, the SOC appear to inform the process of accessing medical transition for most of the transmen in this sample received. Data reflect much of the gatekeeping measures that the SOC recommend in transmen's pursuit of therapy, hormones, and surgery. Transmen typically had to negotiate psychomedical institutions through the confines of the pathologizing discourse that informs the SOC in order to obtain their

desired gendered bodies. As such, they reported numerous incidences of psychomedical gatekeeping.

EVIDENCE OF RESTRICTIVE PSYCHOMEDICAL GATEKEEPING

The SOC set the stage for psychomedical gatekeeping measures. As mentioned in Chapter 3, psychomedical gatekeeping is the systematic process of withholding or conferring services based on a transgender person's compliance with psychotherapeutic, medical, endocrinal, and surgical regimens and credible gender performance. When gatekeeping functions to withhold or delay medical transition, I refer to it as restrictive. When gatekeeping functions to confer these services, I refer to it as admissive. Both types of gatekeeping occurred among transmen in this sample. While some conceive of gatekeeping as occurring predominantly in therapy settings (e.g., Rachlin 2002; Raj 2002), transmen in this sample reported encountering gatekeeping during therapy and while accessing transition-related services. In these contexts, restrictive gatekeeping included the process of obtaining letters from therapists authorizing transition, dealing with insensitive counselors, providing authorization to medical professionals, complying with the readiness criteria for medical professionals, and conforming to heteronormative and hegemonic masculinity standards of health professionals. In addition, transmen reported other barriers in accessing transition services that further exacerbated psychomedical gatekeeping.

Restrictive Psychomedical Gatekeeping in Psychotherapeutic Interactions—Obtaining that "Golden Ticket"

Most of the transmen in this sample accessed therapy prior to accessing medical transition. As described in the previous chapter, learning about therapy protocol constituted part of becoming informed consumers for these transmen. Their transgender networks of information included messages about the SOC and that medical transition typically required letters from therapists that authorized transition. The SOC specify that the therapist letter should describe "[t]he degree to which the patient has followed the *Standards of Care* to date and the likelihood of future compliance" (Meyer et al. 2001:7). The letter should also explain "[t]he eligibility criteria that have been met and the mental health professional's rationale for hormone therapy or surgery" (Meyer et al. 2001:7). Transmen in this sample reported obtaining letters of authorization that appeared to comply with these guidelines.

For the transmen who obtained letters prior to medical transition, their letters relied on standards informed by the SOC. Some transmen described their letters as appearing like form letters that just inserted individual unique information within a standard format. Kevin explained the letter he obtained from his therapist:

> He had a form letter. He deals a lot with FTMs, so I think he probably just had a letter and plugged my name in and maybe changed a couple of details here and there. But it was only like a paragraph long. It was just like, give this person drugs. [laughs] No, it wasn't like that, it was very formal language. So it was just like, "Kevin [surname] is psychologically ready and has blah blah blah."

M&M could only vaguely recall the contents of his letter, but knew that his therapist also fit M&M's experiences within a profile, "Whatever it specifically said, the such-and-such person fits this DSM profile dadadadada specifically, and the whole transsexual thing.

But it was quoted, so he really took a portion of whatever they say about whatever you fit for that profile. He said that I fit that profile." Within these carefully formatted letters, the SOC also state that the therapist letter should include "initial and evolving gender, sexual, and other psychiatric diagnoses" (Meyer et al. 2001:7). Describing the contents of the letter, Trevor explained that while his fit the standard format, it also included more detailed information than he expected:

> I thought it was just gonna say, "I recommend this person for hormone therapy." And instead it was a page long about my life and what I did and how I was successfully living as a guy as much as I could. She described what I looked like; she made jokes in there about me lookin' like I was 12. And it just went on and on and on. I had no idea it was gonna be that detailed. She said that I was out to my parents, I had heavily considered the impact of how my family, that I was out to my parents and my brother. All of this information, I really don't think [my endocrinologist] gave two shits about, but.
> **Elroi: So did she have to include a diagnosis in that letter?**
> Yeah. She had kind of a form letter that she filled in the middle. And the top was like "as a licensed...." whatever she is, "and practicing under the *Harry Benjamin Standards of Care*," yadda yadda yadda yadda, "I recommend Trevor [last name]," and my social security number and all that stuff. And then at the bottom she wrote something about diagnosing me with gender identity dysphoria, yadda yadda yadda.

Trevor's letter then met the standard format suggested by the SOC, but it also included more detailed information about his evolution as a transman. As these examples illustrate, transmen in this sample typically acquired therapist letters in order to access hormones—one primary form of restrictive psychomedical gatekeeping. In these examples, transmen and their therapists simply played by the implicit rules of the SOC. The therapists authorized medical transition, and provided legitimizing letters to their clients. Transmen expected this transaction based on messages they obtained from transgender networks of information. But not every therapeutic interaction flowed so smoothly.

Restrictive Psychomedical Gatekeeping in Psychotherapeutic Interactions—Insensitive Counselors

Some transmen in this sample reported further restrictive gatekeeping in their interactions with providers beyond the authenticating letter. Some men first accessed therapists who lacked experience in treating transmen and subsequently directed them to more seasoned providers without incident. Other therapists of transmen in this sample expressed disapproval of their clients' decisions, thus introducing an additional hurdle to obtaining hormones.

While many transmen simply had to go through the necessary steps recommended by the SOC in order to get legitimizing letters, some encountered therapists that would not even begin that process. For example, Micah explained how his therapist could not understand his desire for hormones:

> When I was talking about testosterone, that didn't go over, that didn't work very well for me 'cause my therapist asked questions that she could not understand why it was so important for me to be taking testosterone. And I ended up, I got a shot from a friend during that period of time when I didn't have T for a while. And she did understand *that* was a problem, giving me a little lecture about why that's not good for my health care. And I'm like, what's not good for my health care is not having testosterone.

In this case, Micah struggled to convince his therapist that he needed hormones. Despite stating his desire to transition, Micah's therapist would not even consider authorizing medical transition because she did not understand his desire for it. Drew shared a similar experience in discussing his desire for chest surgery with his therapist. Drew talked to his therapist about chest surgery since he planned to have that procedure done prior to starting hormones. But again, she could not understand his desire for medical transition:

> She couldn't understand the trans thing at all. And at one point, my third visit, she made a comment, "I just don't understand why anyone would want to do that to

> their body." And I was like, okay bye! [laughs] That was really all I needed. And I made a note at the time, a mental note. I was like okay, I'm here for other reasons, too. I just won't talk about being trans. And then obviously, once I left her office and wasn't influenced by her anymore, I was like yeah, that's not an option for me. That's what I *have* to be able to talk about.

Drew tried to reason that he could still benefit from therapy without bringing up his trans issues because he accessed therapy for several different reasons. When confronted with a lack of support for his transition plans, he eventually realized he could not do therapy with a counselor who rejected one of his core presenting issues.

In these cases, therapists intended to continue seeing clients grappling with transgender issues despite not understanding or supporting medical transition. Unlike therapists who referred clients elsewhere because they acknowledged their lack of experience and knowledge with trans issues, these therapists disapproved of their clients' intentions and insisted transmen justify their decisions. This form of restrictive gatekeeping preceded any authorization process transmen expected to encounter in seeking access to medical transition. These therapists may not have known about the *Standards of Care*, or they may just have been insensitive to trans issues. While the therapist's intentions and knowledge are difficult to gauge, these transmen left their offices feeling like another barrier was placed in front of them. As informed consumers, they knew they might encounter therapists who mistreated or refused to assist trans people. Their networks of information alerted them to the potential for this type of restrictive psychomedical gatekeeping.

Restrictive Psychomedical Gatekeeping in Accessing Medical Transition—Handing the Letters Over

Restrictive psychomedical gatekeeping also occurred among health professionals responsible for enabling medical transition. Because therapists and physicians work together in enforcing the *Standards of Care*, medical doctors expected to see proof of counseling before administering services. When M&M questioned needing approval for medical transition, his therapist reasoned:

> He actually said, "All illnesses do [need some kind of verification]. You can't just walk into the hospital and say guess what, I have cancer. They still might run some sort of test to make sure what kind." I don't think it was a *great* analogy, but I think he tried to say, "Okay, just everybody just off the street just can't walk in and say, 'Guess what, I am this person and give me some hormones.'"

Indeed, the SOC state that one therapy letter is adequate in authorizing hormone therapy or chest surgery (Meyer et al. 2001:8). However, the HBIGDA views genital surgery much more seriously. For FTMs, genital surgery may include external genital procedures as well as removal of internal reproductive organs, according to the SOC (Meyer et al. 2001). For these surgical procedures, the SOC "generally" require two letters from mental health professionals, or one letter signed by two therapists of different professional status and varying relationships to the patient (Meyer et al. 2001:8). The HBIGDA does not explain why transgender people seeking genital surgery need additional authentication, although I argue this extra gatekeeping measure stems from cultural anxiety around genitals as a compelling gendered characteristic, a point I will discuss later.

In accordance with the SOC that mandate some form of documentation, most transmen in this sample reported providing therapist letters to their hormone-prescribing

doctors and surgeons. But despite the ways the SOC portray the gravity of transition decisions, transmen in this sample reported that presenting therapist letters in procuring transition services was a fairly unremarkable transaction. Most doctors providing transition services to transmen in this sample still enacted restrictive gatekeeping measures by requiring letters before administering services. However, they did not make a big deal about it.

Transmen in this sample explained how medical professionals accepted authorization from mental health professionals. Jack explained that his doctors were not exactly following the SOC, although they still wanted a therapist letter, "They weren't going Harry Benjamin, they just wanted to cover their asses and make sure that somebody had already said independently, 'Yep, he's got GID.'" This quotation exemplifies how doctors that provided transition services still needed external validation and authorization in order to treat someone, and thus represents a form of restrictive gatekeeping. But Jack's doctors did not fuss over the letters or stress their importance; they just wanted to have a document in their files. Adam also explained the process of authorization initially required for chest surgery:

> I think they sent me a packet of introductory materials the first time I contacted the office.... And one of the things that it said was, "We will require a letter from your therapist."
> **Elroi: Did it just say it that ambiguously, or was it more specific?**
> I don't even remember precisely what the words were, but paraphrasing it, was something like, "[W]e will require a letter from your therapist certifying your readiness for the surgery."

In this case, Adam's experience reflected the surgeon's need for independent authorization. The surgeon could not just perform surgery to create a male chest. Instead, the surgeons' office informed Adam that he had to bring proof that he reached

this decision in consult with a licensed professional. Although the request did not detail what the letter needed to convey, the surgeon still required one. This surgeon also did not deal with health insurance companies, so his motivation for recording outside mental health evaluation was not based on coding issues for insurance purposes. Based on everything Drew had heard about psychomedical gatekeeping, he eagerly supplied the therapist letter to his endocrinologist even though she appeared less concerned with having one in her hands before prescribing him hormones:

> And she had asked if I had a letter, and I said yes. And I didn't give it to her at that point. And then it was funny because, that first day, she was like, "Okay well I want you to come back at two o'clock." And they called in the testosterone prescription to a pharmacy, or she wrote it to me, and I guess we went and filled it. She was like, "Go pick that up and then come back at two, and we'll show you how to do this." And at that point I was like, do you want the letter? And she was like [rushed, an afterthought] "Oh yeah, yeah." So it was kinda like a formality for her, too.... I think she respected that I had a relationship with a therapist who wrote me a letter. That was kinda all she needed to know. She didn't even really need to read the letter, I think. I handed it to her and she kinda looked over it. And she was like, "Okay good." She has to keep one on file. But there was no validating my experience or anything. Like I remember the first thing she said, she's like, "So you're trans." And I was like, yeah. And she was like, "Okay," and she just went from there. That was all we had to talk about with that.

Drew's experience highlights how medical practitioners might view the therapist letter as a mere formality in administering services. Indeed, most of the men in this study did not describe presenting the therapist letter to medical providers as a monumental transaction. No transmen in this study recalled any remarkable incidents in providing this letter. This suggests that while the SOC place great importance on authentication of transsexual status through counseling, medical practitioners view the letter as a minor formality in administering transition-related care. This would suggest that medical providers simply

want the letter in their patients' files as a legal guard against malpractice worries or possible regretful decisions among patients.[20]

Requirements for legitimizing letters demonstrate how transmen must obtain transition services within the confines of a pathologizing discourse. If a woman wants surgery for breast augmentation or reduction, she would not need any legitimizing authorization from a mental health professional. The desire to enhance one's gender expression is acceptable, as long as this enhancement occurs within a linear gender framework. For those sexed female at birth and socialized as girls, obtaining medical procedures to enhance cultural standards of femininity is perfectly acceptable and even encouraged. For those sexed female at birth and socialized as girls, obtaining medical procedures to enhance cultural standards of masculinity is cause for alarm and warrants intervention from mental health specialists. Transitioning, then, disrupts the linear gender path. Psychomedical institutions deem this action disorderly, indicative of mental disarray, and in need of external validation before fruition. Although medical doctors may ultimately view the letters as unimportant, they typically still required them before providing transition services.

Restrictive Psychomedical Gatekeeping in Accessing Medical Transition—Exercising Excessive Caution or Quality Health Care?

Transmen encountered barriers to transition that were not always clear-cut examples of restrictive gatekeeping, and transmen did not always experience them as

[20] While a few transmen in this sample speculated that their doctors wanted letters in their files only to avoid malpractice, I have minimal support for this claim. During a presentation at a transgender conference I attended in 2006, a surgeon stated that he followed the SOC to maintain coverage with his malpractice insurance company.

prohibitive. Some of these obstacles to transition could arguably be viewed as being in the patients' best interests. These experiences happened in both therapy sessions and interactions with medical doctors. While some transmen viewed prerequisites to transition as quality health care, others experienced them as additional gatekeeping burdens.

Indeed, some transmen described prerequisites to transition positively and did not view them as barriers. These incidences included therapists who would not authorize transition until they believed their clients were ready. These therapists imposed requirements that they believed would help the transmen in their decisions to transition. Kevin reported that his therapist wanted him to come out to his mother, but explained that this was because his therapist knew that Kevin viewed this step in transition as important. Sam's therapist required that he have a support system in place before he would write the letter:

> He didn't push me in any way. He took his time. He asked a lot of questions that needed to be asked. And it wasn't all easy. I think he was fine with me being anywhere I needed to be. I don't think he had an agenda to help you get into transition. Just really wanted to, I guess make sure that I considered everything. And that he needed to assess if I had enough support, too, at the time. And that was one of his requirements, was that I was gonna have somebody with me, throughout the transition, not do it alone.

In these cases, therapists provided services that they believed aided their clients. Sam and Kevin felt positively about their therapy experiences. But due to the therapist's position of power in that relationship, such requirements can sometimes act as barriers to care. While they likely help the transmen in their processes, they still function as criteria to achieve prior to acquiring the authorization for entering medical transition. They

therefore constitute restrictive gatekeeping practices even when transmen do not view them as problematic.

In addition to therapists, medical providers also imposed extra measures before meting out transition services. Although Jesse had been on T for years, an LGBT clinic refused to prescribe him T because he had not done blood work nor endured a physical exam with their providers. Jesse resented this because he just wanted to continue his hormone therapy. Micah encountered similar resistance of this type at the same LGBT clinic. Before he found a trans-positive nurse practitioner in this clinic to work with, his previous provider there was "ridiculous and intense and gatekeeper-y about testosterone." He explained that this provider would not approve him for T because he had not completed different health procedures she deemed necessary, including a chest sonogram:

> She didn't have any reason to believe that testosterone would impact anything that may or may not be going on with that. But she was concerned that there might be something that she didn't know, I guess. When I first went, she insisted that I get a flu shot before she would let me continue the process of getting approved for testosterone. A flu vaccine is necessary to get testosterone? That doesn't really make sense to me.

Health care providers may believe their cautious attention exemplifies their desire to do no harm. For example, requiring a complete physical before administering hormones might simply be providers erring on the side of caution in treating transgender people. But as informed consumers well aware of gatekeeping practices, many transmen interpreted this caution as excessive and unwarranted. Many transmen did not view these prerequisites as quality health care. Rather, they truly resented them for stalling medical transition.

Transmen reported encountering these incidences with individual doctors in private practices. But about half of the transmen in this sample accessed the LGBT community health clinic mentioned above by Jesse and Micah. This clinic stood out in this study as imposing a variety of gatekeeping measures on their clients, including requiring longer periods of therapy for younger patients and prescreening exams that transmen viewed as excessive. Before going to this clinic, John had already started medical transition. Despite being fairly established in his transition, this clinic would not prescribe him T:

> [They] won't prescribe me T, though they've been doing my blood work, which is kinda weird. I've been on T for a year and a half now, and had top surgery. And they've been doing my blood work, and I have a letter from a therapist. But because I went to therapy for two months instead of four months, and I'm under 21, they won't prescribe me hormones. Which has been a *really big* pain in the ass. Because it's the only affordable way that I know of to try and get a 'script, or to access hormones in [this city]. So basically they were like, "Well, you have to go back to therapy for a few more months." And I really resented that.

This clinic refused to prescribe John T because he had not met their therapy requirements for starting hormones. John believed this requirement was excessive and ridiculous. Micah also experienced excessive barriers to transition at this clinic:

> I really was not a big fan of their particular gatekeeping process which made me go through a full physical and which had me answering tons of personal questions to multiple people. And, well I guess it was only two people, but still. [laughs] And then they're supposed to bring your case before a trans committee or something to decide if they approve you or not.

In order to get hormones through this LGBT clinic, Micah had to explain his desire for transition and experience with therapy to two providers, who then brought his case to a larger committee to review his request.

The SOC allow programs to determine their own timelines and protocol for transition (Meyer et al. 2001), so this practice is permissible. However, this protocol

differs from the practices of individual providers operating out of private offices that do not exclusively cater to LGBT communities. This difference represents a great paradox: transgender people access clinics that cater to their needs expecting a sense of transgender awareness, yet such places can impose greater barriers to transition. Some of the transmen who used this particular site ironically reported encountering the strictest limitations concerning medical transition. This paradox illustrates that even when providers commit to providing quality transgender health care, their execution of such services may ultimately function as additional barriers to transition.

Restrictive Psychomedical Gatekeeping—Gender Profiling

One of the most interesting, albeit troubling, forms of restrictive psychomedical gatekeeping enforced heteronormativity and hegemonic masculinity. Prior to transitioning, some men in this sample expressed worry over having to present a conventional gender identity in order to gain access to hormones and surgery. This anxiety resulted from messages they had heard about transmen needing to successfully pass as masculine and heterosexual men or transsexual men in the offices of therapists, doctors, and surgeons. Ultimately, about half of the participants in this study reported this form of restrictive gatekeeping. Based on these data, I refer to this type of psychomedical gatekeeping as “gender profiling.”

Gender profiling is the practice of upholding a set of characteristics and behaviors based on conventional or stereotypical understandings of gender and using that limited understanding to assess an individual’s ability to successfully pass in society as a woman or man. In psychomedical institutions, gender profiling occurs when medical and mental

health professionals withhold or confer transition services based on the gender presentations of transgender people. This concept expands theoretical understandings of "doing gender" in that people perform and confirm socially constructed concepts of gender through interaction (West and Zimmerman 1987). Indeed, actors within psychomedical institutions are not immune to the process of doing gender for their transsexual clients. However, the way they do gender rests on a distinct position of power wherein they possess the authority to transform the gendered characteristics of transgender people. Thus, gender profiling among psychomedical institutions adds a new dimension to doing gender that subjects transgender people to a particular gender performance. Transsexuals must successfully present and perform gender for psychomedical authorities in order to gain the medical services that will transform their bodies in the gendered ways they desire. In gender profiling, health professionals that provide transition-related services function as enforcers of the dichotomous gender regime. Transmen in this sample encountered gender profiling at every turn in their transition processes.

Some of the men encountered gender profiling in therapy interactions. At this junction in transition, transmen had not yet accessed medical transition. They did not have the benefits of hormonal masculinization or any surgery to aid them in presenting masculine or male gender identities. During adolescence, Leroy sought therapy because he wanted what he knew of then as "a sex change." His therapist, however, told him that his gender desires were not possible:

> [My parents] sent me to this, this woman who told me that I could never be a man. And I could be any kind of woman I wanted to be, but I was always going to be a woman. But that part, not so bad. It's okay, I can see that line of reasoning. But then she would also say some really fucked up things to me like, "Do you

> think anyone would ever want you to date their daughter if you were? You wouldn't really be a real man." Like all kinds of weird, sort of twisted things that are really just self-shaming. And she was pretty awful. And I went to her for a little while, until—I've always been attracted to girls—she said something to me like, "So do you think you might be ready to start dating boys?" And after that I was like, what?!

In therapy sessions, Leroy's counselor repeatedly told him he would never measure up to a "real man" and would never be viewed as a desirable partner within a heteronormative framework. In her eyes, Leroy would never measure up to her standards of maleness. She attempted to counsel Leroy into becoming a heterosexual woman—the only acceptable standard that fit her gender profile for her young client. Nate experienced similar gender profiling in getting counseling to work through his gender issues:

> I got this therapist through this lesbian therapist referral network, and this woman was just horrendous. She was like, [grumbled voice] "Well you don't seem male to me," and [laughs] "What do you mean you're a transgender?"
> **Elroi: She was a lesbian?**
> Yeah, and I was just tentatively coming out of the closet, and she's like, "You don't seem masculine to me," and just saying the worst thing anyone can say to somebody who's starting to question their gender. And so that was just horrendous.

This therapist's gender stereotypes acutely impacted Nate. In response to this message, he returned to the closet for two more years, thinking that maybe he really was a butch lesbian, or just crazy for expressing those desires. Even with a lesbian therapist who exists outside of normative gender and sexuality due to her queer sexual identity, Nate encountered gender profiling. Anecdotal evidence suggests such clinical transphobia can occur among gay and lesbian therapists (Raj 2002). Nate's therapist did not think he appeared male and could not understand his desire to transition.

While the counselors that Leroy and Nate saw did not approve them for transition, Jack worked with a sex therapist who "wasn't very good" and schooled Jack in

successfully passing as a man before authorizing transition. Although Jack thought these lessons were ridiculous, he was willing to endure them because this therapist would eventually authorize him for medical transition. "He thought that his job was to school me on body language, and he just had a really weird, strict take on what a primary transsexual looks like and how to make me conform to that model." Jack said that his therapist instructed him on the proper way to hold a cigarette as a man, the appropriate type of underwear, and other "really stupid stuff." Jack deduced that his therapist did this in order to help Jack pass the real life experience portion of the *Standards of Care*. This therapist believed that part of conferring transition services meant ensuring that his transgender client embody rigid understandings of conventional masculinity.

As the above examples illustrate, transmen encountered gender profiling among therapists. Gender profiling in therapy contexts contributed to some transmen's anxiety over successfully passing as men. Since transmen typically accessed therapy prior to any kind of medical transition, these health providers represented powerful figures that held the authority to grant access to hormones and surgery. Even when Adam expressed more worry over being accepted in the trans community than by his counselor, he understood the power that his therapist had in validating his identity:

> I think a lot of my anxiety when I was just starting to come out was about not being trans enough, or not being allowed to be under the trans umbrella or other trans people being suspicious of me. I was worried that they would be, because they would see me as not legitimate somehow. And I knew that, at least the story that I had, my history, my gender expression, my gender identity, and plus my current identity at the time that I was in therapy was not sort of the standard transsexual narrative. And I didn't know what that meant in terms of my legitimacy as a trans person. So I was worried that, when I was going into therapy, that he would be sort of this arbiter of transness and tell me, oh you actually, you don't qualify.

This perception of therapists as "arbiters of transness" was fairly common among the men in this sample. Transmen believed that gender profiling among therapists would weigh heavily in their decisions to approve or deny medical transition.

In addition to therapy contexts, gender profiling occurred during interactions with health professionals who administered hormones or performed transition-related surgeries. Drew described an encounter he had with an endocrinologist he considered using for his hormone therapy. Drew wanted to feel out different providers and viewed this visit as more of an interview process. He came prepared with questions and brought a friend along to take notes:

> He came in; he never introduced himself.... And it was the strangest conversation. He first asked me to qualify my being trans. He was like, "Well how do you know?" And all of this. And so I kinda gave these general answers and then he was like, "So you're interested in starting T?" And I was like, yes. And he's like, "Do you know much about it?" And I said that I did, that I had a lot of knowledge from reading about it and also knew friends who had gone through it. And one of the things he kept saying over and over is, "Well you know, no two people are gonna go through it exactly the same." While it was a valid point, I felt like he was being really condescending. And I was like, not thinking that I will—I'm just ready for it. He kept addressing the things that I could anticipate happening, which I'd already said I was really aware of what was gonna happen. So he was really stuck on facial hair, and he was like, "You know you won't have a full beard within a year." And I was like, yeah I know that. I'm not looking for that. And he said that three or four times. And I was really like, you're not listening to me. Then he was talking about building muscle and he was like, "Do you work out?" And I was like, yeah. He was like, "Well you're really gonna see a big difference. I've seen some guys come in here that just look like bodybuilders. They look like regular men." And I was just like, what conversation are we having? 'Cause I really wanted to go in, ask him what the process was gonna look like working with him, and just general things. And he kept mentioning the beard. My friend and I laugh about it now, just 'cause we were like, *okay*! I don't care! I'm not trying to have a full beard in a year. And it was like a twilight zone episode.... I mean, both [my friend] and I were like, this is crazy. If this was a brilliant surgeon who was the best at what he does, and I could understand if his social skills weren't great, it would be a one-time thing, that would be fine. But this is someone I had to be able to have open dialogue with, and I knew it wasn't gonna happen. So we left.

During this encounter, Drew felt like the endocrinologist was not listening to him and the exchange was just generally odd. But part of the negative exchange also involved gender profiling. The endocrinologist stressed stereotypically masculine features like a full beard and huge muscles. In relaying what Drew could expect from starting testosterone, the doctor imposed a rigid gender narrative by imagining that Drew would want conventional male features, consequently stressing Drew's prospects for a beard. But Drew told him that he knew about that already, and was instead interested in determining whether he could receive quality care from this provider in terms of administering and monitoring hormone levels. Also note that in Drew's account of the exchange, the doctor differentiated between "some guys" that are trans and "regular" men. This subtle language difference, as Drew relayed it, suggests that the doctor may think that some transmen do not successfully pass as men. Perhaps this is why he stressed a particular gender profile upon Drew. Later in the interview, Drew thought some more about this interaction:

> If he was just trying to establish why I was there, would be one thing. But the way that he paused and the way he waited for me to answer was like, you better *prove* to me that you are, or I'm not gonna help you. And so, I can just remember answering kind of short phrases, like yep. And he would fish, and I don't think I really said very much. I essentially just said, yes, I've always known. I really wanted that portion of the appointment to be over with.

From this quotation, it becomes clear that Drew viewed this interaction as restrictive gatekeeping through gender profiling. He felt like he had to prove to this doctor that he was transgender in order to get hormones. When John interacted with his chest surgeon, he speculated that the surgeon disliked John's gender presentation. He wondered about the surgeon's cold and moody demeanor, "Maybe it's because I'm here with my really genderqueer partner, or because I'm not fitting some model of what a transman should,

not like a heterosexual in khakis or something." John's gender profiling experience with his surgeon did not affect his ability to get surgery, but he connected his failure to meet conventional gender standards with substandard treatment.

These experiences with gender profiling show that restrictive psychomedical gatekeeping may sometimes depend on stereotypical notions of gender and sexuality. Some health care professionals denied transition services if transmen failed to meet their gendered expectations. This form of gatekeeping underscores the ways that deviations from linear and normative gender paths obstruct transmen's pursuits of the bodies they desire. Gender profiling, then, contributes to the ways transmen must conform to confining discourses about transsexuals. Despite expressing gender and sexuality in diverse ways, health providers occasionally expected transmen to fit into conventional standards of hegemonic masculinity (Connell 1987).

Additional Obstacles that Exacerbate Restrictive Psychomedical Gatekeeping

Some of the experiences relayed by respondents in this study were not definite examples of restrictive psychomedical gatekeeping. Some respondents described numerous factors that functioned as further barriers to medical transition. As such, these experiences acted as additional obstacles that intensified the more unambiguous examples of restrictive gatekeeping. Barriers to quality care included situations where transmen encountered insensitive providers. For example, respondents reported many examples of providers using incorrect pronouns or revealing obvious discomfort in treating a transgender person. Many respondents also reported seeing providers who were completely uninformed about trans issues, causing transmen to seek care elsewhere or

work to educate providers about their health care. Some transmen expressed willingness to educate providers who lacked transgender awareness, but others felt uncomfortable doing so. Zed explained that his doctor felt willing to administer his hormones after receiving a therapist letter, but also wanted more information about transgender people:

> The letter was definitely good enough for her, but she did want to talk to me, too. And I think that was more of professional and personal curiosity. And she didn't do it in a freak show way, which was good. But I think she realized that there *is* a group of people who are not getting serviced and not getting well served, and not having their needs met by the medical community. So her questions, some of them were personal but most of them just had to do with ways that she could be more sensitive to my needs and other trans people's needs. So I felt very comfortable answering her questions. And also I knew that she was a friend of a friend. So I was more okay with some of the more personal questions that were her just trying to learn, whereas somebody who went to her afterwards felt uncomfortable with some of those questions. Someone I know didn't like the experience that they had with her, but I was fine with it.

In this situation, Zed felt comfortable educating his doctor. Zed also volunteers in the trans community and educates the public about trans issues. He had experience educating people, whereas someone else in the same situation felt put off by this provider's questions. For this transman, her personal inquiries were too invasive.

One exceptionally negative barrier included being denied care outright by providers. Micah relayed one such experience, "I called up a primary care physician, and I asked if he would be comfortable treating a transgender person and he said no, and hung up." M&M's experience characterized a fairly typical encounter with an insensitive provider who was unwilling to administer hormones for transition. In this encounter, he described going to a health clinic that catered to low-income people that he had used for years when he discovered that his old doctor had left and his medical records had disappeared:

> I told [the new doctor], “I need my prescription renewed. And was told by the [pharmacist] you need to write me a new prescription.” [The doctor asked,] “What kind of stuff?” And immediately when I told him what it was, you could see, he freaked. And he was saying, “Why you takin’ that for?” And then I had to decide, okay gotta tell this guy. And it was really uncomfortable. He went out the room. And he came back in chastising me that I didn’t tell the nurse what was going on and it was just crazy and weird. And I was like, all I want is a prescription. And he was tellin’ me he didn’t do that and he couldn’t do that. And I said, well I’ve been comin’ here forever getting the prescriptions. And he still wasn’t comfortable. He actually walked over [to the pharmacist]...basically to verify if what I just told him was true.... And he was even rude to him when they checked on it. Some people have their personal opinions about this whole thing, and you could tell he probably was uncomfortable with it immediately. He went ahead and filled it, but I knew I couldn’t come back there. He basically told me, you can’t.
> **Elroi: Did he give you a reason why?**
> He basically said he didn’t do that kind of medicine.... But he told me on the way out again—he was in the hallway with people out there, so I didn’t even feel comfortable to hardly ask him additional questions—he just sorta said, “Okay we’ll go ahead and refill it.” And then as he was walking by, he said “I can’t, I won’t be able to refill it for you again.”

Despite having a history at this clinic, M&M was unable to continue getting hormones there due to the replacement doctor’s discomforting with treating trans people. In this way, the doctor’s refusal to continue M&M’s hormone therapy represented an additional burden. M&M then had to find a different provider who would continue his treatment.

While these situations did not constitute explicit restrictive psychomedical gatekeeping, they represented barriers to care and confirmed some of the messages respondents heard within their networks of information. Many of these transmen knew that negative experiences were rampant in doctors’ interactions with transgender patients and had heard horror stories about health providers denying care to trans people. These experiences fed into the increased anxiety and apprehension many transmen reported based on messages they had heard. Men who received poor treatment confirmed what they had already heard through their own experiences. For some of these men, this treatment also influenced problems with health insurance coverage.

Many transmen in this study reported problems with getting transition services covered by health insurance. Some investigated coverage for these services, as Micah explained, "I called the health insurance company that I had and asked them about coverage of any trans-related care, just to see. And they were like, 'No, no,' and hung up." This experience was fairly typical because most public and private health insurance companies explicitly state they will not cover services related to transition (Goodrum 1998; Hong 2002; Lombardi 2001).[21] In addition to this halting barrier, transmen in this sample described instances where providers or their office staff elected to expose their transgender status to insurance companies. Since Micah knew his carrier would not cover his transition, he chose to keep his transgender status hidden while getting general health care in order to avoid complications. However, he explained that the receptionist at his university health clinic exposed him:

> They wrote on all of the referral stuff and prescription stuff "Patient is transgender and takes testosterone. Patient is transgender and takes testosterone."...
> **Elroi: Why do you think they wrote that on your prescription?**
> I don't know.... Nobody has ever considered whether or not I'm transgender relevant to write on any sort of a referral or prescription before for me in my life. It was very unusual, but I guess the information really made an impression on her. [laughs] And she decided to share it with anyone else who might come in contact with me. And which again was a concern for me 'cause this is something that *does* get submitted to insurance, I'm quite sure.

Drew also explained that his endocrinologist recorded his transgender status on his paperwork knowing that her decision would mean his insurance would not cover the hormones:

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[21] For example, Pearce and Pearce, Inc.—Georgia State University's newly mandated health insurance company for funded graduate students—states in its "Program Exclusions" that it will not pay "for surgery and/or treatment of...sexual reassignment surgery" (2006-2007 Mandatory Student Insurance Program). Http://www.studentinsurance.com/PearceSite/Schools/GA/gsu/PDFs/gsumb0607.pdf. Retrieved on September 9, 2006.

> [Your trans status] is on your little form and it checks transsexual. And as soon as that happens, insurance doesn't cover it.... I respect that she's going by the books..., but it's really hard to see that on your sheet and just know that whatever you do—conversation, blood work, anything—*will not* be covered or touched by insurance. And she even said, "You can try to send this in, but I've seen it tons of times, as soon as that's checked, they're not gonna cover anything."

Although Drew could understand her professional reasons for doing so, his endocrinologist's decision still impressed upon Drew the fact that his trans status was going to be a barrier in getting his health care covered by insurance. One transman social worker in the sample elaborated on the effects of such decisions:

> I just had a client tell me yesterday that they went to the doctor on a referral to a gynecologist, and the gynecologist's secretary called up the health insurance company and said, "I have a transsexual male in my office," and basically disclosed this person's information. And the domino effect that that could have could really ruin this person's health care.

The tenuous relationship many transmen had with their insurance companies intensified their negative experiences with providers. But even when coverage was threatened, the experiences of transmen with insurance were often better than those without insurance. Insured transmen were able to get most general health care covered as well as some of their transition-related services, such as blood work monitoring. Many more men in this sample did not have this privilege, and their socioeconomic status limited their health care possibilities.

Financial limitations among transmen in this sample added to their barriers to medical transition and health care in general. Transmen without insurance typically relied on clinics that often had long wait lists with inconsistent providers. Before Jesse moved to New York, he accessed services for free in an exceptional clinic based in San Francisco. When he relocated, he thought that the community LGBT clinic would

operate the same way. He learned quickly that it did not, and that he needed to find an alternative to continuing hormone therapy:

> I didn't have any money, and I just assumed, oh, well it should be just like San Francisco where you walk in and it's sliding scale and everybody's happy. But they were like, "Okay, well it's $50 to see the doctor today." And I'm like, I don't have 50 bucks. And they were like, "Well then, you can't see the doctor today." And I'm like, well, what if I truly don't have the money? I don't have a job yet and I just moved here and I need health care. They're like, "This is our sliding scale, it starts at 50 and it only goes up from there." So if you're broke, you're not getting any health care, regardless of if you're trans or not. You're just not getting any health care. It *really sucks* actually. It makes me that much more thankful that I lived in San Francisco.... I probably wouldn't have been able to transition if I lived in New York City back then when I was younger and wanted to transition. I had *no fucking money, no means* of paying 50 bucks every time I went to see the doctor. Back at that time I was seeing the doctor a lot.... But that probably would have cost me hundreds of dollars. And even [the New York clinic] was saying even blood work would cost me $75, probably would've costed me between 500 and a thousand dollars, which is insane.... And thankfully, nothing bad during the times when I didn't have insurance happened to me, thankfully. Because then I would've been *fucked*! I would've been totally fucked, totally and completely.... I remember when I didn't have insurance and I was obviously looking like I had been on testosterone for a while. And I was like I just need a prescription for T, and they were like, "Well that's just not the way it works. You would have to come in and do the whole blood work thing." And I just didn't have the money. So I was totally turned away. And I even remember, I was like, well then I can't have this appointment. And they were like, "Oh. We're sorry."

Jesse's experience demonstrates how lacking funds prevented him from continuing transition at this clinic. For transmen like Jesse, not having enough money represented a barrier to care and contributed to feelings of being kept from transition. In these cases, programs and practices that imposed financial restrictions enacted a very basic restrictive gatekeeping measure—affordability. Fortunately, Jesse lived in a city where he was able to start transition without paying for it. But not all transgender people can or want to live in San Francisco, and are therefore not able to access such resources.

When interactions with providers proved dissatisfying, some transmen's financial limitations felt more salient, prompting these respondents to speculate on the intentions

of health providers. At times, transmen in this sample felt that providers catered to transgender populations so that they could profit from a community in need. They reasoned that these providers probably felt like they could do whatever they wanted to because transgender people depended on them for care. After a bad experience with a chest surgeon, John believed, "I really felt like he was like capitalizing on trans bodies," explaining:

> I think it's all about money with him. He charges way more than like he has to. The surgery was in total of 7,000 and he got 4,500 of that. But that's not including hospital fees or anything, that's just what he's making. And he did two surgeries that morning. So that's $9000 and he does that three times a week. And all he has to pay is rent for his office space and he has one assistant. Even just with the follow-up care..., his demeanor really *changed*, and I felt like that was because he had my money and had done the surgery. And he has this policy about after you've given him that money, all follow-up care is free. I've gone back *since* ...and been like, can you just look at my chest and tell me if everything's okay? And he's always been really rude and short with me. I feel like it's really obvious to me, 'cause he's not profiting on [aftercare] at all. And I think that that really has a lot to do with how the health care system here [in the United States] has worked. I feel like a lot of doctors are—especially someone who's a straight man who's a plastic surgeon—he doesn't really care about trans people. He's obviously in it for the money. It's like he found this niche which can be capitalized on and...he sort of built up this rapport and everyone goes to him now. And he's making a lot of money. I think he also thinks that he can get away with it 'cause he *knows* that he has this reputation of a lot of people going to him. And he knows that there's not that many surgeons out there, and that he does a good job. So he's like, "What is it, if I'm rude to one person?" It doesn't really matter to him. I don't think he feels like he has a lot to lose.

John's bad experience with this surgeon informed his opinion of the surgeon's ultimate motivations for catering to the transmen's community. Even when Solomon viewed this same surgeon's work, he was not impressed with the results and felt most surgeons' work lacked quality, "They just don't seem all that concerned to me with long-term results, or end results. They're like, [in rushed voice] 'Okay, well who's your insurance? How much have you got? And boom—let's just do this." For Solomon, surgeons seemed

willing to take trans people's money and operate, paying little attention to their craft. This opinion reflected his distrust for providers who specialized in trans services, which Solomon viewed as an obstacle to quality health care.

While surgery represented a fleeting interaction with one part of the health care system, hormone therapy required more consistent interactions with providers. Some transmen felt that doctors were in the business of hormones knowing they could turn profits from trans people. When Drew had a negative experience with an endocrinologist, he offered this viewpoint, "It felt like this doctor found an area of expertise that he could benefit from because he knew that guys were looking for this. And he knew that he could get a lot of patients that way. So he really seemed to be capitalizing on a business level." Drew's feelings about this endocrinologist echoed Solomon's beliefs about surgeons, demonstrating that some transmen viewed temporary procedures and recurring interactions similarly. M&M continually pleaded with his doctor to write him a prescription for T. But his doctor kept insisting that M&M come in for his shots, forcing M&M to pay upwards of $75 for each weekly visit.

> Every time I'd go and see [my doctor] and like, all you gotta do is write me this prescription [because] it was cheaper for me and just a big hassle. I got to take off work and come down here. And he said, "Oh I'm not comfortable. Who's gonna give you your shots?" And he would have this whole little conversation and then he'll say, "Next time." He was this really hurried kind of guy every time you saw him.

The doctor's refusal to write a prescription prevented M&M from maintaining his transition on his own very basic terms. While the doctor did not prevent M&M from accessing transition, he repeatedly denied him a prescription that would last him several months and save him hundreds of dollars. A few other respondents also reported that their therapists would only provide individual authorization letters each time they needed

a particular transition service, without giving the patient a copy for himself and demanding fees for each letter sent. Such economic motivations led some transmen to feel disempowered in obtaining quality health care for their transitions. While these examples did not represent outright restrictive gatekeeping, they exacerbated problems with accessing transition. When these barriers occurred in concert with other more explicit restrictive gatekeeping measures, they contributed to transmen feeling like their health care was out of their control and that they must submit to the protocol of psychomedical institutions.

Encountering insensitive providers, being denied health care, worrying about insurance coverage, costly care, and money-hungry doctors can all be considered negative experiences that function as barriers to health care. Logically, none of these experiences were desirable among transmen. They were unequivocal hurdles to quality health care. In this way, these additional obstacles to transition and general health care services exacerbated the experience of restrictive gatekeeping for many men in this sample. These experiences were not just examples of substandard health care or annoying obstacles that all health care recipients must endure. They occurred in a context where transition services are pathologized. When transgender people's desires for transition-related services require constant authorization and verification from psychomedical institutions, the otherwise average annoyances of health care become increasingly salient. They serve as reminders to trans people that trans health care warrants regulation above and beyond usual health care protocol. As such, these negative incidences exacerbate the restrictive psychomedical gatekeeping that affects so many transmen's experiences with health care systems.

Despite these examples of restrictive psychomedical gatekeeping, such practices were not inevitable in all circumstances. Transmen in this sample reported experiences that reflected a notable absence of restrictive gatekeeping. These experiences are also important to consider, because diminished and nonexistent restrictive gatekeeping can illuminate the reasons why it occurs in other settings.

EVIDENCE OF ADMISSIVE PSYCHOMEDICAL GATEKEEPING

In some instances, transmen reported that they did not experience or only encountered minimal restrictive psychomedical gatekeeping practices. These reports demonstrate evidence of admissive psychomedical gatekeeping in that transmen's health providers conferred access to medical transition with little or no delay. Transmen encountered admissive gatekeeping when providers viewed them as competent enough to make transition decisions, when they presented normative gender or other valued social statuses, and when providers were inexperienced or delivered inferior health care. These experiences are important to note because they highlight circumstances in which transmen may circumvent the normalizing discourse of negotiating transition within the confines of pathology.

Admissive Psychomedical Gatekeeping—Acknowledging Transmen's Competency

Many men in this sample reported admissive gatekeeping among their health care providers in accessing both therapeutic and medical services. Most of the men in the sample who did not express problems with restrictive gatekeeping in therapy sought care from trans-friendly providers that were well aware of the power dynamic at work in their

interactions. In Micah's first therapy encounter, he did not encounter any obstacles, "She was like, 'Okay, you seem competent to make this decision for yourself. Go for it.' Which I appreciated because I was competent to make the decision for myself." Drew's therapist also respected his decision to transition, and did not impose any special requirements in their meetings, "Fortunately for me, this particular therapist was ready as soon as I was ready. 'Cause when I directly asked her if she'd done that before and written letters, she had. So it was on *my* timeline. It was on *my* watch. And that was exactly what I needed. *Un*fortunately, I know not everybody has the same experience." While Drew encountered admissive gatekeeping with his therapist, he knew that his experience was not typical. Messages about restrictive gatekeeping among therapists saturated transgender networks of information, so when transmen had no troubles with their therapists, they felt appreciative.

As strategies to minimize restrictive gatekeeping during therapy, a few transmen accessed services from transgender-identified providers. These practitioners seemed more sensitive to psychomedical gatekeeping having gone through transition themselves. While some of these transgender providers did participate in restrictive psychomedical gatekeeping to some degree, transmen viewed these counselors as trans-aware and sensitive to the ways the *Standards of Care* enforce linear transition. John explained how he accessed counseling to procure the legitimizing letter, "I didn't even wanna go to therapy, but before starting T, I just went to get a letter…. I went to a counselor…and he was actually a trans guy. So, it was really easy. I just went in, and talked to him. And he was basically like, 'I'll give you your letter whenever.'" Similarly, Trevor negotiated a therapeutic relationship with a transwoman counselor, and acknowledged:

> She's trans herself, and so I think she can kind of see where [needing a letter is] sort of fucked up and like a gatekeeper kind of a thing. But it's also, I guess from a therapy perspective, can be sort of beneficial to the person. But regardless, she said that she followed [the SOC] so that she would be more respected, I guess, in her profession.

Kevin saw a transman therapist who seemed more understanding of where Kevin was coming from:

> When I walked in there, the whole gatekeeper stuff was in the back of my mind. And I'm like, look, this is what I wanna do. And he's like, "Well let me see you for a month, and I'll write your letter in a month." I know it's usually a 3-month period where they make you wait before they write you a letter for hormones. But for one thing, he was just really easy-going about that part of it. Because I'm like, look I've been thinking about this for 14 years, so. He was really willing to work with me. Also, he's an FTM as well, so he'd been there before.... He's just been really able to help me with everything, because it's like he's been there before. And he's not at all judgmental.

Interestingly, while his therapist wanted to see him for a month prior to writing the letter, they only met monthly. So Kevin got his letter on his second visit. In addition to the way his therapist instilled faith in Kevin's decision to transition, Kevin also really appreciated the way his therapist was able to provide guidance through his transition. These transmen downplayed and rationalized restrictive gatekeeping by accessing therapists who were transgender and seemingly more sympathetic to the gatekeeping process.

These counselors acknowledged that their transmen clients were fully competent to make decisions about their own lives and bodies. They supported transmen's decisions and did not enact additional barriers, such as gender profiling or imposing restrictive time limits. In some cases, these providers were also transgender and understood the process on a more personal level. But as Drew's experience demonstrates, nontransgender therapists could just as confidently support transmen in their decisions. Although all of

these therapists provided legitimizing letters typically required by medical professionals, they participated in this form of restrictive psychomedical gatekeeping because following the specifications of the *Standards of Care* enabled transmen to access medical transition. After all, writing letters was usually the main reason why transmen sought their care. But in a few cases, transmen were able to access medical transition without therapists' letters.

Most of the men in this sample had to obtain a letter from a therapist certifying that they had a gender disorder in order to start hormones or get surgery. Some men, however, were able to access medical transition without the legitimizing therapist letters. One did not need a therapist letter because he worked as a gender counselor and had established relationships with other providers in the community that never questioned his decisions. This transman said that they "kind of figured that I had it figured out, which I did." His doctors acknowledged his competency to transition because they knew he counseled people dealing with gender issues. For a few men, their doctors also acted in a counseling capacity, and thus directly evaluated transmen's decisions. Jesse did not need a letter from a therapist, and reasoned it was because his attending doctor assessed his mental health over time:

> I think primarily because I had been going to the doctor, and she was basically assessing me because we would have long talks. And I think she felt okay, this person has enough understanding of what's happening. I mean, it was about six months, and I saw her a few times within that six months where she was like, "Okay, well we're just going to get you started on it and see what happens."

Through these long talks, Jesse's doctor was able to discern his mental health for herself and felt comfortable starting his medical transition. SpiritTrans also did not need a therapist letter and reported a similar experience with his doctor. But SpiritTrans also mentioned to his doctor that he was in counseling, and speculated that this information

likely impacted the doctor's willingness to prescribe hormones without a legitimizing letter.

The above examples demonstrate admissive gatekeeping due to providers' trans-awareness, trans status, or general acceptance of transmen's competence and mental health. One transman avoided restrictive psychomedical gatekeeping by starting chemical masculinization through a nonprescription alternative. Adam did not need a therapist letter because he started transition through an over-the-counter hormone spray, which masculinized his body such that his doctor viewed prescription testosterone as simply continuing his care:

> I got the gel prescription from my primary care physician who had known that I was using the pro-hormone spray and I had even shown her the bottle of the spray.... So when I told her that I was ready to start prescription testosterone, she immediately wrote the prescription and did not require any kind of therapist's letter or anything like that. Because in her eyes, I had basically already started medical transition and was clearly functioning. It was working out well for me so far and she did not feel that she needed any more assurances about that. So definitely not *Standards of Care*, but [laughs] but you know, sort of harm reduction, in a way. But I was very grateful that she did not create a roadblock for me to doing what I felt was right for me.

Later in the interview he elaborated, saying that this doctor felt "less apprehensive or cagey about starting me on the prescription because she saw what she was doing as just continuing this course of treatment that I had already put myself on." Adam used this spray to achieve lower masculinization than what prescription testosterone produces, not to avoid restrictive gatekeeping. However, this alternative to medical transition enabled him to obtain a prescription without having a legitimizing therapist letter. For his doctor, Adam's decision to alter his body chemically through a pro-hormone spray was convincing enough to continue this masculinization process through more potent

hormones. Because he already started inducing testosterone's effects, Adam's doctor felt he was competent to continue the process medically.

Other transmen reported that being further along in transition aided admissive psychomedical gatekeeping. Being established on prescription testosterone enabled many transmen to continue hormone therapy with different doctors and access surgery. When transmen had started medical transition and the effects of testosterone produced visible results in their appearances, they reported fewer problems with accessing T in circumstances where they needed care from new providers. Transmen typically dealt with new providers because they or their doctors moved to different cities or in cases when their original providers retired. John described this experience:

> I'm already on T so it's been really pretty easy for me to get a 'script, because they've been like, "Oh, you're already on T," and then I don't have to jump through all the hurdles. I think once you've started hormones, there's this validity or something, it's like, oh, okay, you're really a transsexual. You're really doing this, now I feel fine about writing you a prescription.

John's experience highlighted how being established on T led providers to view him as competent in continuing transition. Providers may also feel more comfortable continuing care knowing that someone else before them had already enacted the appropriate restrictive gatekeeping measures. When I asked Andrew whether his current endocrinologist required a letter or if being on T for three years was enough, he replied, "Yeah, I think that was enough for him! [laughs] I already had whiskers. It was pretty well obvious what was goin' on. Not to mention, I signed the release for him to get my records from the other doctor, too. So if he really wanted to go that far, I guess he could get her copy of the letter." Adam also reported a lack of restrictive gatekeeping after being established on T for years:

> It has seemed to me that doctors don't, that the decisions that they make are really informed by what has come before. And I guess the *Standards of Care* sort of bear this out, they're really framed around *starting* hormones, and they have all these suggested steps for what has to happen before you start hormones. But it seemed to me like once the hormones start, there's this sort of momentum that gathers, medically speaking, and that doctors feel, I mean no doctors have ever really said anything to me about this, but I've just gathered that once you're on that train, they become a lot less concerned about keeping the momentum going.... I don't know if there's also a fear of liability that's related to getting the letters, where doctors want some reassurance that if they help you make this major change, you won't then turn around and blame them for having screwed up your life or whatever. But once you are on T, you have already crossed that line and what you're asking them to do by writing the prescription is less dramatic, because it's just a continuation rather than an initiation. So that has been my, the conclusions that I've drawn, is that once things get going, people sort of relax about the hoops to jump through.

These experiences were common for men well into their transition. Since the SOC are primarily concerned with starting hormones and accessing surgeries, then maintaining hormone therapy seemed less risky for providers. In addition, the effects of testosterone in these men enabled them to pass more easily and more often than when they just started hormones. Doctors likely read their gender presentations and their desire for hormones as congruent, and did not feel like what they were doing would alter them in any major way.

Interestingly, being established on T also enabled transmen to access surgery without providing therapist letters. This admissive gatekeeping is in contradiction to the recommendations of the SOC, which state that surgeons performing transition-related procedures should obtain therapist letters before operating on transgender patients. When I asked Jesse why his chest surgeon did not require a therapist letter, he explained:

> I think because the nurse that he works with asked, "How long have you been on testosterone? How long have you been living as male?" And I was just like, three years.... It's like have you been living as male for long enough, then we'll trust you that you're, that's the way you're gonna go.

Kevin had not been on testosterone for very long before he accessed chest surgery with the same provider Jesse used. He called the surgeon to learn what he required before the procedure, “He was going to require a letter because I had not been on testosterone for a full year. So I think that’s his deal. Like if you’ve been on testosterone for a year, he doesn’t require a letter. If you haven’t, then he does.”

The experiences of Kevin and Jesse offer a revealing comparison. They both used the same chest surgeon, but Jesse had been on hormones longer than Kevin. The doctor did not impose the additional restrictive gatekeeping measure of requiring a letter for Jesse, but he did for Kevin. This discrepancy in treatment demonstrates that some surgeons may base their decisions on a case-by-case basis. When prospective patients have undergone hormone therapy for years, then surgeons likely view them as more competent to make transition decisions and may refrain from gatekeeping. They likely view transmen who have been on T for years as more competent to make decisions about their bodies and gender expressions.

The incidences that acknowledged transmen’s competency occurred in a variety of situations. Health providers neglected to impose restrictive gatekeeping measures because they were sensitive to power dynamics in transition. Doctors also placed little importance on therapist letters because they felt transmen were competent enough to change their bodies. Finally, transmen’s history of hormones also prompted doctors to avoid imposing restrictive gatekeeping measures. These circumstances affected ways doctors acted as gatekeepers. They exist in stark contrast to the restrictive gatekeeping measures experienced with other providers who were insensitive, unsympathetic, or

excessively cautious about granting transition. But other social factors also aided the possibilities of admissive gatekeeping.

Admissive Psychomedical Gatekeeping—Gender Profiling

Just as gender profiling functioned in provoking restrictive psychomedical gatekeeping, it also worked to inspire admissive gatekeeping if transmen passed the same heteronormative ideal. In the previous section, being established on T worked to enable men access to continued hormone treatment without incident. While the data in these encounters did not explicitly suggest gender profiling, they most certainly could have. Meaning, doctors could have seen men and granted services because they did not question these men's gender. After being on T for years, transmen easily passed as men.

Transmen in this sample reported more overt gender profiling in interactions with health care providers. Some reported admissive gatekeeping due to gender profiling during therapy. In these examples, transmen successfully presented gender expressions that therapists deemed suitable for transition. In this way, gender profiling worked to confer transition services. Dave's interactions with his therapist suggest that she perceived him to present an adequate male identity:

> **Elroi: What did she tell you the process was going to be like for therapy?** She said that she usually normally sees somebody at least, sometimes four to six months, maybe a year before she will send them to a doctor and have them go on with their trans process. I seen her less than a month, and she had told me on my second visit, she says, "I really don't need to see you anymore for this. We'll go ahead and let you set up your appointment to see [an endocrinologist]," she says, "because I knew when I first looked at you that this was a thing that had been bothering you and been part of your life all of your life." And she says, "After talkin' to you for 10 minutes, I knew it would be okay just to sign the papers for you and go on, because you had already had enough of this!" And she said "It is a gender issue and we're gonna solve that," she says, "but I wanna keep talkin' to

> ya and I wanna find out about how your life has been," she says, "because you're honestly one of my older patients and I'm interested."

Dave was in his fifties when he decided to transition and walked into this therapist's office. Interestingly, she told him that she knew by looking at him that he had struggled for a long time with this issue. Prior to transitioning, most peopled perceived Dave as a butch or masculine woman. He is a big guy who lives with his female partner and blends easily into society. This experience demonstrates how presenting a masculine gender can sometimes work to transmen's advantage in seeking authorization for transition. While rare, this experience reveals how gender profiling can enable transition services.

Gender profiling informed some providers' treatment of transsexual patients and occasionally aided transmen in their interactions with endocrinologists or other doctors who administered their hormones. When Trevor inquired about starting on testosterone gel instead of injectable testosterone, his endocrinologist explained that she did not start transmen on gel due to its slower, subtler changes. He reacted, "I did think it was a little weird that she saw that as a reason why no guy would want to start on Androgel. Because I've got some friends who prefer that and they've been doing that for a while. And they might stop and maintain some kind of genderqueer androgynous look. It kind of rubbed me the wrong way." Trevor's doctor believed transmen wanted quicker, stronger masculinization and resisted prescribing them a treatment that she deemed ineffective for the results she imagined all transmen wanted. It did not occur to her that some guys do not want to appear like superbly masculine men. For her, transmen represented a homogenous group who wanted immediately obvious masculinization, and this gender stereotyping informed her treatment of Trevor. Adam saw a doctor who prescribed T based on her perception of the transmen that entered her office. This example is one of

the most extreme cases of gender profiling, and offers a comparison point to Trevor's doctor's assumptions because Adam actually wanted the slower effects of Androgel:

> There were transmen in that community who didn't like this doctor because she would just make her mind up based on her own opinion about people. And would deny testosterone to people just based on, I guess her own instinct about them. And so, when I went to her and asked for the prescription for gel, she said to me, "Well you look male to me." And wrote her prescription.... She made this flippant "you look male to me" comment, which of course was exactly what I wanted to hear, because it meant, she said it pretty much as she was writing the prescription. But I think there were transmen who *didn't* look male to her that she gave a much harder time to, much to their great dismay and outrage. But that was the extent of it. We didn't have a, you know, let's talk about why you're not following the *Standards of Care*, kind of conversation with her. She figured that I had figured that out for myself.

Because Adam had already starting masculinization through a pro-hormone spray, he appeared more male to this doctor than other transguys who had not had that opportunity. She waived the restrictive gatekeeping measures recommended by the SOC because Adam fit within her gender profile of what a man should look like. These experiences of looking or appearing like men also helped transmen access surgery.

Several transmen in this sample experienced gender profiling during interactions with surgeons who provided trans procedures. When Nate met with a surgeon for metaoidioplasty, the surgeon's gender profiling affected their interactions:

> He doesn't know much about transmen, really, *as people*. He knows his science. He knows the body. But he's like, "Hey man! How you doin'?" His bedside manner is very macho. And I think he was trying to make me feel comfortable by affirming my masculinity, but it made me feel kinda like, I can't exactly be myself here.

Nate's surgeon imposed a conventional gender profile in their interactions. While he may have believed he was acting appropriately, he actually made Nate more uncomfortable because Nate has a sweet demeanor and a nonthreatening posture—not at all macho. Joey described encountering gender profiling in surgery consultations:

> I'd been to surgery consultations where the surgeons were very forthright, just grabbing on my chest. I mean, really disrespectful. I walked in to one of them, and he was like, "Oh yes, you should definitely be a man." I mean it was ridiculous. I wasn't asking him whether or not I should be a man.

In these examples, surgeons felt compelled to validate transmen's gender presentations. They relied on conventional understandings of masculinity and heteronormativity in their interactions. They did not appear to understand that transmen exhibit as much variation in masculinity as nontransgender men. As these experiences demonstrate, surgeons could also use gender profiling in conferring surgeries. Perhaps they were even more likely to hold these views due to their short-lived interactions with transmen. While endocrinologists have the opportunity to develop long-term relationships with their transmen patients, surgeons typically only see transmen several times.

Unfortunately, gender profiling was not limited to transition services. Some transmen encountered gender profiling during general health care interactions. While Jack reported positive experiences with his physician, he knew that other trans people who had seen his doctor left feeling unsatisfied. When I asked him why he thought people had such different experiences with the same providers, he replied, "I really think it's about passing. I mean, doctors are people, too. And they look at you, and if they see a girl, they're gonna stumble on pronouns even when they know they're supposed to be addressing you as boy." Jack's reasoning suggests that doctors do gender based on physical cues. But as mentioned earlier, such missteps affect transmen more seriously because of the nature of psychomedical gatekeeping.

Even in interactions with general providers, transmen may deal with health professionals who misperceive their gender expressions. As members of psychomedical institutions, these doctors represent authority figures even when they do not provide

transition services. As such, they can still make a transman feel like their gender needs to be defended. One time Micah requested that his doctor use language that reflected his gender identity. He wanted the doctor to refer to his chest. Instead, the doctor refused and lectured him about how such language was incorrect:

> And the doctor who I saw before, when I said something about that after she *didn't* use that word, she gave me this whole speech about how there's an anatomical difference between chest and breast. And so she was just going to continue using that word, which is completely irrelevant as far as I'm concerned. She's not conveying any different anatomical information to me by using a word that is less traumatic.

While she did not insist that Micah present a certain gender, she imposed a limiting narrative on his body based on gender profiling, despite his request to the contrary. Such interactions are not overt examples of gender profiling. Rather, they exacerbate the experience of psychomedical gatekeeping and gender profiling in that they relate to transmen's gendered requests.

The gender profiling that occurred within health care systems sometimes positively affected transmen's access to transition services. When providers believed transmen met heteronormative and hegemonic ideals or assumed that they wanted to meet them, they were more likely to enact admissive gatekeeping measures. Transmen who more closely resemble this ideal or do not challenge it much may then be able to use their gender expressions to their advantage in accessing medical transition, but more data are needed to explore this possibility. These experiences confirm the importance of presenting normative gender and sexuality in negotiating confining discourses that regulate transsexuals' transitional journeys. The importance of hegemonic gendered social status complemented other factors that aided in transmen's access to medical transition.

Admissive Psychomedical Gatekeeping—Social Status

In addition to normative gender presentations, two transmen also reported that another socially prized characteristics enabled them easier access to medical transition. These men worked in occupations with professional prestige. One worked as an attorney, and another was a social worker that specialized in gender counseling. In some instances, providers viewed these men as more competent because they worked successfully in respectable occupations.

The social worker explained that he easily accessed surgery and hormones. First, he sought chest surgery and explained that he did not encounter any problems. He reported that his surgeon had not started requiring therapist letters at the time of his surgery[22] and operated on a case-by-case basis. Her policy enabled him quicker access, and he attributed this to his occupation, "I'm sure her lack of reluctance to, because they took everybody on a case-by-case basis, they could turn anybody away that they want to. I'm sure she felt better knowing that this is the work I did." This social worker also accessed hormones as soon as he requested them, without needing a therapist letter and without his doctors insisting on following any aspects of the *Standards of Care*, "Once I *decided* definitively to take testosterone, I *had* testosterone. Quickly. Probably easier access than *most* because people *knew* I was a mental health professional, and nobody questioned me. So, that was not a problem." For this respondent, working within transgender-specific health care aided his access to transition and he did not encounter any obstacles to hormones or surgery.

[22] This respondent accessed chest surgery in 1998 or 1999. The *Standards of Care* were in print at this time, but this surgeon had not performed many chest surgeries for transmen. It is possible that she did not know the guidelines the SOC recommend for transition-related surgeries.

Similarly, an attorney in this sample reported less difficulty in accessing hormones and surgery, and believed his profession partially influenced this lack of gatekeeping. In accessing hormones with his doctor, this respondent thought that his occupation enabled him speedier access, "My impression was that she took into account that I was a professional.... I think that her read of me was that I...was functioning well, was a successful adult. I think that definitely worked to my advantage." When this respondent then decided to get chest surgery, he encountered a similar lack of gatekeeping. In addition to the fact that he was already established on T, his occupation aided the surgeon's decision to waive his usual requirement that patients present a therapist letter prior to surgery. He explained how his correspondence with the surgeon confirmed this respondent's suspicion that his social status enabled admissive gatekeeping:

> [My conclusions] were that I feel like I've definitely benefited from the fact that I have a professional job, that I'm an attorney and people hear that and presume a high level of functioning and give me the benefit of the doubt, where if I told them I was unemployed, or that I worked at a McDonald's or something, that I don't think that I would necessarily get. And I think it's also race privilege. I think the fact that I'm white has worked to my advantage, not surprisingly in our society. But being a white professional who is in his late 20s, and not 19 or something, has also helped. So the fact that I told him in this paragraph, I'm 28 years old, I'm an attorney, I transitioned, I think I told him I started my transition while I was a law student and have been on prescription testosterone for three years, I live and work as a man. Will you require a letter from me? And then his response to that paragraph was, "Based on the information that you have shared, I will not require a letter." So I think that it was very clear that, the impression that I got was he was saying, "Okay, you've clearly dealt with all the hard stuff. You seem stable. You seem smart and competent, I'm not going to make you jump through this hoop."

While this respondent is drawing his own conclusions about the surgeon's reasons for waiving the letter, it seems clear that based on their written exchange, the surgeon valued this respondent's social status. In addition, this respondent acknowledges that his

whiteness has aided him in transition. Some of the white transmen in this sample attributed their more positive experiences to race privilege. So not surprisingly, white privilege affected interactions with providers. The few transmen of color in this sample did not identify much race-based discrimination among their interactions with providers. One respondent of color felt that a black Caribbean health care worker treated him poorly due to her own homophobic views, but further research should explore this realistic possibility in more depth.

These examples of prized social status contributed to admissive gatekeeping within psychomedical institutions. When respondents presented class and race privilege, they sometimes reported getting easier access to transition services. Of course, not every transman in this sample acknowledged this privilege. But even when respondents did not recognize how their social status may have benefited their transitions, social statuses likely affected all of their interactions due to the ways race, gender, and class contribute to unearned privileges in all aspects of stratified society.

Admissive Psychomedical Gatekeeping—Inexperienced, Second-Rate, and Profit-Hungry Health Providers

The previous examples that illustrated admissive psychomedical gatekeeping stemmed from providers that acknowledged patient competency due to respecting transgender people's decisions. Or, they valued the social statuses of these transmen based on their race, class, or gender presentation. But other examples that transmen identified revealed more dangerous reasons that providers enacted admissive gatekeeping measures. In a few cases, these health providers were unfamiliar with protocol for

treating transgender patients. In others, doctors provided substandard health care that was sometimes driven by profit. These factors limited restrictive psychomedical gatekeeping, but they also limited transmen's experiences with comprehensive, quality heath care.

A few of the men in this sample encountered admissive psychomedical gatekeeping because they worked with providers who had little or no experience with transgender patients and were unfamiliar with the *Standards of Care*. These providers did not require letters because they did not realize the SOC encouraged this requirement. Kevin explained accessing hormones through a doctor that had never met a transgender person and worked out of a rural area in New Mexico, "He would've probably written me the prescription without the letter, 'cause he just didn't know. He was just like, "Oh. I need this? Okay. I'll stick it in this file." But he had never encountered a transperson ever before." Kevin explained that this doctor was exceptionally "cool" because he accepted him as a transman without judgment, and was willing to start him on hormones without worrying what this decision might mean for Kevin or for his practice. Kevin's doctor ultimately initiated contact with another more experienced health provider, and consulted with him to provide Kevin with quality care in terms of monitoring hormone therapy. Had the doctor already had knowledge about hormones, this lack of hindering medical transition would represent an ideal situation for transmen who are ready to start hormones. But this outcome did not transpire for other transmen.

Some men in this sample traded quality care for accessing medical transition with admissive psychomedical gatekeeping. While Micah appreciated one doctor's willingness to prescribe him testosterone without issue, he acknowledged that he also

sacrificed quality health care with this provider. This doctor was unwilling to discuss hormone options and Micah did not even know what kind of practice he operated:

> He was perfectly fine in that he would write me a prescription immediately. The only thing that was a little bit difficult with him was that it was really hard to engage him in a conversation. He wasn't really interested in hearing questions, and was very, very short. I was still confused about why they had me on this different dosage and he kept forgetting what dosage I was on, telling me that I should just do the regular dosage. And I was like, okay, but why, like what they would have done. And he was like, "Oh well you can do their dosage too if you want." And I'm like, but is there anything about having different dosages that is related to anything. I couldn't start that conversation.
> **Elroi: What kind of doctor was he?**
> I don't even know. Somebody told me he was a hematologist, actually. [laughs] I don't know what he was doing prescribing hormones, but he did. [laughter] He took enormous amounts of blood from me, though. He took more blood than any doctor. And he also wouldn't tell me what he was testing my blood for. I would ask and he would tell me a couple things, and then he would get the results back and he wouldn't tell me what the results were. And I would ask and he would tell me results for things that he hadn't told me he was testing me for. It was just like he wasn't giving me a ton of information. And he was also fine, though. He would just write me a prescription, and let me go on my way. He didn't give me any trouble about getting testosterone. I just would have liked to be able to talk a little bit more about dosage and stuff.

Similarly, John described seeing a doctor for hormones and not receiving quality care, "It was really easy to just go in and get a 'script from him. But then there was absolutely no follow-up." These cases demonstrate that transmen expressed willingness to sacrifice quality health care if it meant they could access testosterone without having to endure restrictive psychomedical gatekeeping. While it is difficult to ascertain why these the providers enacted admissive gatekeeping measures, some transmen's admissive gatekeeping experiences seemed related to doctors' financial motives.

In some cases, transmen also received medical transition services without restrictive psychomedical gatekeeping, provided that they could front the funds for these services. Some transmen in this sample reported getting hormones from doctors who

appeared willing to prescribe testosterone without any objection because transmen were willing to pay cash for their services. M&M explained how he worried about discussing his trans issues with the doctor because he was nervous about being able to start hormones:

> As soon as [the doctor] came in the door, [the receptionist] said, "That's him." And I asked, can I please talk to him quickly in the back. And then I was goin' through this whole thing about I'm transgender, I was goin' through this whole spiel and feelin' so emotional, and my life is in this guy's hands. And he was sort of like, brushed me away and said, "Okay." And I had my letter out and I was trying to tell him and he was like, "Oh okay, well go in there and tell her." It was sorta like, why you even tellin' me this kind of crap. It was an experience. I mean, I never had conversations, that's the most I talked to that guy the whole time I went to him. He was thinkin' like, probably in between me telling him whatever, he cut me off, and said, "60 bucks and pay the lady at the thing." It was just weird.

In this case, M&M's doctor also did not provide quality care. He never monitored M&M's hormone levels or did any blood work. In fact, M&M reported that he was unsure what dosage he was getting during the entire time he was under this doctor's care. This experience demonstrates that some providers profited off of transgender patients. They were willing to provide hormones when transmen could afford them. Enacting restrictive gatekeeping measures would run counter to their desire to profit, and thus explains why M&M's doctor gave him hormones without problems or any aftercare.

In these examples, transmen encountered admissive psychomedical gatekeeping because they saw providers who lacked experience, provided inferior health care, or provided care based on profits. While they were able to access transition services with ease, they risked doing so with more incompetent providers. These transmen forfeited quality health care in circumventing the restrictive psychomedical gatekeeping practices outlined in the SOC.

Consequences of Psychomedical Gatekeeping

Based on the mental disorder diagnosis of Gender Identity Disorder that informs the guidelines outlined in the *Standards of Care*, transmen must negotiate their desired bodies within the confines of pathology. The psychomedical institutions that pathologize transgender identities and experiences produce a normalizing discourse that regulates how transgender people may alter their bodies. Despite inherent contradictions in the SOC, many health care providers rely on rigid understandings of eligibility criteria for medical transition. This reliance leads to psychomedical gatekeeping, granting health care providers the power to confer or deny transition-related services.

As evidenced in this study, transmen encountered a variety of restrictive psychomedical gatekeeping routines. They entered into health care systems as informed consumers, and expected to encounter many of the incidents relayed in this study. They accessed therapy to obtain legitimizing letters for medical transition. They also encountered insensitive therapists that placed additional obstacles in their paths. Since therapists and doctors worked cooperatively in authorizing transition, transmen also experienced restrictive gatekeeping in handing therapists' letters over to their medical doctors. Although most of these physicians accepted the letters as simple formalities, some enacted further restrictive gatekeeping measures by exercising excessive caution in administering hormones. In interactions with therapists, physicians, and surgeons, transmen in this study experienced restrictive psychomedical gatekeeping in the form of gender profiling. Their health providers occasionally expected transmen to fulfill hegemonic masculine ideals. And additional obstacles to health care served to exacerbate

transmen's experiences with restrictive gatekeeping by reminding them just how much their health care was out of their control.

But while restrictive psychomedical gatekeeping confirmed the ways transmen had to negotiate bodies within the confines of pathology, admissive psychomedical gatekeeping also exposed this process. Some health care providers believed transmen were capable of making their own decisions about their own bodies and subsequently practiced admissive gatekeeping. The ways that these providers viewed prohibitive psychomedical gatekeeping as unnecessarily restrictive will be explored in the next chapter. These examples demonstrate that health providers may also disagree with the normalizing discourse that regulates the policing of trans bodies. But other providers simply felt willing to continue transition services because transmen had already started the process. This occurrence suggests that sufficient masculinization may limit restrictive psychomedical gatekeeping, and likely connects to the ways these providers view transmen's continued care as staying within normative gender. By continuing their hormone therapy or providing FTM surgery procedures for transmen with noticeable effects of testosterone, these health professionals supported gender profiling in that they only aided the transmen on a path that they had already traversed. In this way, gender profiling both prevented and enabled transmen access to medical transition. When transmen met heteronormative, hegemonic ideals, they encountered admissive psychomedical gatekeeping. Additional social markers like class privilege also worked to their advantage. And in a few cases, transmen dodged restrictive gatekeeping in interactions with providers who lacked experience or delivered substandard care.

Different circumstances dictated different experiences of psychomedical gatekeeping. But as some of the examples presented in this chapter implied, transmen and their health providers did not always submit to the normalizing discourse. In negotiating health care systems through the confines of pathology, many transmen and their providers actively manipulated and resisted the sanctions outlined in the SOC. These experiences highlight the dialectical struggles between psychomedical authorities and transmen patients who utilized their care. Transmen actively and intentionally participated in these discourses, and appeared to willingly participate in their own domination—a Foucauldian concept of power as productive. Ultimately, however, all agents in these interactions had to succumb to the overriding power of the binary gender system. The concept of dichotomous gender framed every aspect of the *Standards of Care*, medical transition, and delivery of services. Even when transmen objected to binary gender, their decisions to change their bodies had to be understood within a conceptual framework that allowed for two and only two genders. These experiences and their theoretical relevance will be explored in the next chapter.

Chapter 5—Negotiating Bodies within the Confines of Pathology

> *[T]rans people had to 'pass' the 'examinations' of the psycho-'experts,' who acted as the gate keepers to the medical professionals who would provide the hormones and surgery that I knew were essential to not only enhance my life, but in order to keep me alive. As such the psycho-experts became the enemy I had to either persuade to believe me or to defeat (regardless of whether they believed me or not) in order to enter through the gateway. Yet—I also discovered that the psycho-experts were contained and controlled by both the overarching assumptions of their own disciplines, and the schools of theory they belonged to within those disciplines: that it is possible to find scientific evidence to 'truths' which have some sort of universality, but that that universality depends upon the paradigms of the theoretical understanding of the nature of 'human-ness' and its interaction with society, and culture.* –Stephen Whittle (2006:197-8), on the dialectical struggle within psychomedical institutions

Through a process of becoming informed consumers, transmen prepared for their interactions within psychomedical institutions in accessing medical transition. They were familiar with the guidelines that regulate medical transition, the *Standards of Care* designed by the Harry Benjamin International Gender Dysphoria Association, and expected to encounter providers who adhered to them. As the last chapter demonstrated, psychomedical gatekeeping included complex processes of withholding and conferring services based on respondents' adherence to standard protocol. The overarching classification of transsexual procedures as indicative of Gender Identity Disorder frames the ways transmen must negotiate their desired gendered bodies within the confines of pathology. In this way, deviations from linear gender paths in a binary gender system become subjected to corrective lenses. This chapter contextualizes the aforementioned research findings within a poststructural theoretical construct. It will demonstrate that transmen's negotiation of psychomedical institutions and gatekeeping provides an empirical understanding of the Foucauldian concept of power as productive and regulated by the disciplining practices of both institutions and the self. Further data illustrate this

process, implicating transmen, their providers, and larger regimes of truth that maintain the gender binary system.

DISCURSIVE POWER IN TRANSSEXUALITY—UPHOLDING GENDERED REGIMES OF TRUTH

Poststructuralism offers a compelling theoretical perspective to understand how transmen negotiate bodies within the confines of pathology. Gramsci (1971) argued that people make sense of their identities within the context of cultural references. Through social structures like the family, church, and school, cultural references become hegemonic. Individuals willingly participate in domination through an articulation of identity using these cultural references. Historically specific culture and cultural ideology, then, represent integral forces in maintaining hegemonic systems of domination. Each of these systems enforces and reinforces binary understandings of gender.

Foucault expanded on Gramsci's assertion that people willingly participated in domination through cultural articulations and shifted the focus onto bodies and sexuality to understand discursive power. He contended that domination could only exist if people expressed willingness to be dominated. He argued that individuals do not internalize subordination passively, but actually produce their own subjectivity. In *Discipline and Punish*, Foucault developed the notion of power as productive, meaning that power ascends from individuals:

> The individual is no doubt the fictitious atom of an "ideological" representation of society; but he [sic] is also a reality fabricated by this specific technology of power that I have called "discipline." We must cease once and for all to describe the effects of power in negative terms…. In fact, power produces; it produces

> reality,…domains of objects and rituals of truth. The individual and the knowledge that may be gained of him [sic] belong to this production. (Rabinow 1984:205)

Elaborating on the concept of productive power, Foucault argued that people subscribe to varying regimes of truth without any kind of coercion. Because no one entity exists to subordinate people, hierarchies of power disappear. Instead, regimes of truth exist to maintain the conditions that allow people to continue to live their everyday lives, and each produces its own discourses. People participate willingly in these regimes of truth, leaving no escape from the discursive world.

In this study, the most relevant "discipline" is the psychomedical institution, and these technologies of power form social ideology. As a society, we have pathologized transsexual experiences. We view the decision to make gendered changes to the body that deviate from nature's typical trajectory as belonging to the domain of medical and mental health disciplinary practices. Thus, psychomedical institutions regulate the body when individuals wish to alter it in this atypically gendered manner. Through this process, psychomedical institutions impose and subscribe to a regime of truth that pathologizes transsexual experiences and identities and maintains the gender binary. Transsexuality retains classifications in diagnostic manuals as symptomatic of mental illness and in need of treatment and management by psychomedical authorities**.** This perspective and management constitutes the normalizing discourse for transsexuals. The normalizing discourse is the psychomedical management and treatment of transsexuals who seek medical transition. It designates a disorderly status to transsexuality and directs transition through a pathologizing framework that warrants constant validation, authorization, and legitimization. In doing so, the discourse reifies dichotomous gender

by conferring medical transitions that allow bodies to move from one sex to the "opposite" sex.

Foucault explained that individuals are both an effect of power and an element of its articulation. Foucault argued in *The History of Sexuality* that "[p]ower is everywhere; not because it embraces everything, but because it comes from everywhere" (Foucault 1978:93). It ascends from individuals. Consequently, individuals represent the most important creator of their own subjectification. Without power, there is no individual. They cannot be separated because both articulate the effects of power. Thus, Foucault resisted understanding power as something that must be overtly exercised over individuals.

In this study, transsexuals were not immune to productive power. This means that transsexuals, as individual elements of their own subjectivities, utilized the same regime of truth employed by psychomedical institutions. They did not simply succumb to the whims of domineering psychomedical professionals. Familiar with the normalizing discourse, transsexual men in this study asserted consciously constructed narratives to access medical transition. They employed the discourse that pathologizes their experiences. This chapter will illustrate this process as dialectical—one where transmen did not simply submit to the discourse, but articulated it in asserting subjectivity and as the primary way they could pursue the bodies they desired. Foucault's notion of "bio-power," or power at the cellular level, is wholly literal here in that transmen employed the discourse so that they could change their biological forms. They participated in the normalizing discourse to produce their own subjectivities as altered by hormones and

surgeries. Transmen's process of productive power renders them the subjects and articulators of a pathologizing discourse.

According to Foucault, power also produces different regimes of truth in each society. Individuals experience power as knowing, knowable, self-knowing subjects. This process of subjectification renders individuals the subjects of the regimes of truth, which cannot be separated from who we are. Disciplinary practices produce subjectification of individuals, or docile bodies, but they also allow individuals to produce domination upon themselves. Foucault explained this concept of the creation of docile bodies in *Discipline and Punish*:

> The human body was entering a machinery of power that explores it, breaks it down, and rearranges it. A "political anatomy," which was also a "mechanics of power," was being born; it defined how one may have a hold over others' bodies, not only so that they may do what one wishes, but so that they may operate as one wishes, with the techniques, the speed, and the efficiency that one determines. Thus discipline produces subjected and practiced bodies, "docile" bodies. Discipline increases the forces of the body (in economic terms of utility) and diminishes these same forces (in political terms of obedience). (Rabinow 1984:182)

The regimes of truth in society represent discourses that transform and manage. The discursive transformation in individuals controls societies, while individuals transform their own bodies into manageable subjects through discursive practices. Connecting this theoretical point to this study, it is necessary to view psychomedical institutions as the regime of truth that transforms and manages the pathologizing discourse of transsexuality. Psychomedical gatekeeping mandates that transsexuals legitimize their bodily desires through the normalizing discourse. At the same time, individual transsexuals exploit these discursive practices and so become managed subjects. They invoke legitimizing narratives to gain authorization for medical transition. Through this

dialectical process, they participate in their own domination. However, they do so only out of necessity due to psychomedical institutions' pathologization of medical transition. This pathologization becomes required only as an effect of the larger regime of truth imposed by the gender binary. The pathologization would be unnecessary in societies with less at stake in maintaining two and only two categories of gender.

Transsexuals participate in their own domination because their identities and experiences have been pathologized by psychomedical scientific classification. In *The Order of Things: An Archaeology of the Human Sciences*, Foucault described the process of scientific classification of individuals. He argued that documents produced should be studied for the discourse they embody and exude. In the preceding chapter, I described how the classification of Gender Identity Disorder warranted the HBIGDA *Standards of Care* for providers assisted transsexuals through medical transition. The SOC represent the key documentation that manage transsexual bodies and epitomize the normalizing discourse. My analysis of this document exposed discrepancies in protocol and seemingly arbitrary designations. Yet the SOC continue to inform the management of transition, detailing the normalizing discourse. While they do not take an absolute stance on classifying transsexuality as a mental disorder, their guidelines are certainly framed around this supposition.

Classifying some gendered physical changes as pathological and other changes as perfectly normal perpetuates our society's obsession with maintaining civility in a postmodern era fraught with scientific technologies that transform bodies in unprecedented ways. In *Madness and Civilization*, Foucault elaborated upon the dividing practices in society that serve to differentiate between the normal and the abnormal. He

disconnected “madness” from a strictly mental state, arguing that medical and psychological discourse that distinguished between normal and abnormal functions as a highly effective means of social control. Dividing practices, then, function socially to maintain civility and these disciplinary techniques create uninterrupted and constant docile bodies. For transsexuals, the normalizing discourse relegates their subjectivity to the domain of the insane. The discourse separates transsexual desires for gendered bodies from nontranssexual desires for gendered bodies. For example, the desire for surgically-created double-D breasts in a male-to-female transsexual constitutes an insane desire, whereas the desire for surgically-created double-D breasts in a nontranssexual female constitutes a sane desire. As a society we divide the former action as abnormal and worthy of psychomedical scrutiny, which then separates and normalizes the latter action. The discourse supports linear expressions of binary gender, regulating only those that deviate from normative gender trajectories.

Such distinctions maintain the social control of transsexual bodies. Anyone can receive a prescription for testosterone. Male-assigned, cisgender men can get one if their testosterone levels lag behind “normal” levels. Female-assigned, cisgender women can get one if it will enhance their (hetero)sex drive. Female-to-male transsexuals, however, can get a prescription only if they see a therapist first. They must validate their desires for a hormone-enhanced body. The therapist must authorize medical transition. Transsexuals must continually engage in a unique legitimizing process because psychomedical institutions pathologize their desires for different bodies. In effect, applying this stigmatizing label only to transsexuals keeps nontranssexuals’ desires for different bodies nonpathological. The message is clear. Nontranssexual women who

desire double-D breasts, tight vaginas, and facelifts are simply enhancing their already feminine features. These gendered body modifications do not require validation, authentication, or legitimization from therapists. While they may constitute potentially pathological responses to a culture with flawed standards of beauty, they are normalized.

When female-to-male transsexuals seek physical changes through hormones and surgeries, their desires for these physical changes are coded “masculine;” they deviate from the linear gendered path, and thus all changes they make to their bodies that require medical assistance become regulated wherein psychomedical institutions enforce the normalizing discourse. The body, a most private and personal sphere, becomes differently regulated for transsexuals due to the normalizing discourse. Foucault argued that punishment was not really directed at the body of the individual, but at the souls of the “normal” people in society. Classifying transsexual bodies as disorderly actually serves to maintain normalcy, and this is how the gender binary system is maintained.

Transsexual changes fracture fixed identity in that they question the stability of sex and gender categories that structure every aspect of our lives. By regulating transsexual bodily changes, psychomedical institutions distinguish between sane and insane physical gendered changes. In doing so, they also legitimize transition from one category to the other. They do not support the total destabilization of gender. They do not encourage occupying ambiguously gendered or sexed bodies. Rather, the normalizing discourse structures transsexual changes dichotomously. Transsexuals may leave one sexed category, but they must then occupy the “opposite” category as wholly as possible. They are assumed to want and expected to pursue physical changes that clearly place them into an unambiguously sexed category. The normalizing discourse expects

that transmen want to be men and have male bodies, including hormonal masculinization, chest reconstructive surgery, and genital surgery. Indeed, many transsexual men do want such bodies. Whether transmen want male bodies or not is not the issue here, because the normalizing discourse is not interested in helping transsexuals get the bodies they want. The normalizing discourse is, however, extremely committed to preserving the gender binary.

This theoretical framework can be used to understand how transmen in this sample negotiated their desires for gendered bodies within the confines of pathology. Their use of the normalizing discourse employed dialectical processes of submission, manipulation, avoidance, and resistance. These strategies provide an empirical understanding of Foucault's conceptualization of productive power as informed by regimes of truth.

DIALECTICAL NEGOTIATIONS OF THE NORMALIZING DISCOURSE—SUBMISSION, MANIPULATION, AVOIDANCE, AND RESISTANCE

Data from this study illustrated four key ways transmen negotiated the normalizing discourse in pursuing their desired gendered bodies. Some transmen submitted to the discourse to access medical transition. Others manipulated the discourse to obtain the bodies they desired. A few transmen successfully avoided the discourse through pursuing medical transition in unconventional ways or by using providers who did not abide by the standard protocol. And finally, many transmen in this study resisted the discourse by actively critiquing its purposefulness. Some transmen in this sample employed more than one negotiation of the discourse. These negotiations were

dialectical processes between transmen and the psychomedical institutions they navigated.

Dialectical Negotiations of the Normalizing Discourse—Submission

By submitting to a discourse that pathologizes their experiences, transmen in this sample participated in a dialectical process where they and their doctors defined the terms of their existence. They willingly participated in their own domination by embracing, articulating, and enacting this discourse in their interactions with psychomedical authorities. In other words, they produced their own subjectivities by using the language and terms devised by psychomedical regimes. Simply by accessing therapy to gain authorization for medical transition, transmen appropriated and articulated the discourse that pathologizes their desires for changed bodies. Of course, most of the men who did so had no other choice, and some reported benefiting from therapeutic relationships. The pathologizing discourse, however, regulates medical transition, and transmen usually must submit to this discourse if they want hormones and surgeries. Thus, the ways that psychomedical institutions impose a pathologizing discourse and the ways transmen submit to it represent a dialectical process. Both agents exemplify productive power.

The previous chapter outlined the process of psychomedical gatekeeping. In this study, transmen negotiated psychomedical gatekeeping and submitted to the normalizing discourse differently. A few men uncritically accepted their lot as transsexual men that needed to submit to the protocol of psychomedical institutions. Most transmen in this sample viewed submission as a necessary but temporary means to an end. Finally, some

men viewed it as a loss of power and control over their bodies. These approaches informed the ways they ultimately submitted to the discourse.

A few transmen passively accepted the therapy mandate without question and represent those on one end of the spectrum in that they were complicit with psychomedical gatekeeping. These men did not complain much about psychomedical gatekeeping. Rather, they accepted it as their lot as transsexuals. Some of these men lived in more isolated and rural areas and actually appreciated the way that therapy connected them with larger transgender communities and provided them with access to resources that were unfamiliar to them. Those that found good therapists also benefited from having a therapeutic relationship during a time of great change. However, their complacency with mandatory therapy did not automatically mean that they also believed in the way that discourse pathologized their experiences and identities. None of these men ever expressed feeling like they had a mental illness or wholeheartedly accepted a diagnosis of Gender Identity Disorder. Their submission to the discourse occurred largely out of necessity.

More commonly, transmen viewed psychomedical gatekeeping as a means to an end—their desired gendered bodies. They felt that obstacles like months of therapy and needing letters of authentication were necessary evils in the pursuit of medical transition. Andrew saw a counselor so he could "do that three months and get my letter—like a means to an end." Zed described his therapy experience similarly, "It felt like I was doing what I needed to do to get what I wanted." Responses like these were typical for transmen who submitted to psychomedical gatekeeping and its accompanying

normalizing discourse in order to get what they wanted. They accepted it as a temporary process needed to obtain hormones and surgeries.

Other men recognized psychomedical gatekeeping as a loss of control and expressed dissatisfaction with the process. Nate felt like he lacked agency in his own transition, "There were certain barriers, and it's this feeling of not being in control of your own future when you have to rely on other people to write all these letters to attest to your validity as far as being trans." Before Jack started to access transition services, he felt like it was out of his hands, "Oh God, I'm gonna have to wait for everything. And other people are gonna have to sign off on everything. It's gonna be like I'm in this for the ride, and that I'm not driving this." These men disliked feeling somewhat powerless in obtaining their desired bodies. They experienced submission to the discourse as a loss of agency in making informed choices about their bodies.

Through uncritically accepting psychomedical gatekeeping, viewing it as a temporary means, or even as a disconcerting loss of power, transmen in this sample had to negotiate their bodies within the confines of a normalizing discourse. Although their viewpoints on psychomedical gatekeeping differed, these men ultimately submitted to the normalizing discourse that regulates medical transition. They participated in their own domination by participating in therapy prior to accessing medical transition. Indeed, psychomedical *Standards of Care* require that they comply with these regulations in order to access hormones and surgery. But despite these varying perspectives on the actual process of psychomedical gatekeeping, transmen negotiated this discourse in different ways, suggesting that they did exert agency in navigating these systems. Thus,

their submission to the discourse involved a conscious act wherein they articulated their own subjectivities.

During interactions with therapists, some transmen presented themselves as more confident about their decisions than what they really were at the time. They neglected to confide in therapists about their fears and doubts about transition, worrying that such disclosures would prevent them from receiving legitimizing letters. As John explained:

> When I went to therapy for starting T, I felt my therapist was really really cool, and I could have talked to him about whatever. He was trans, he definitely wasn't wanting me to fit some mold of being, he didn't diagnose me with GID or something. He wasn't into wanting me to be like a real transsexual or something. But I also felt like, I was having a lot of doubts in starting hormones. But I didn't feel comfortable bringing them up with him, because I wanted to just get my letter.

In John's case, he withheld sharing his doubts about hormones because he did not want to be denied a legitimizing letter from his therapist. He submitted to the normalizing discourse purposefully. Zed also explained why he presented himself as more confident than he actually felt:

> I felt like I should appear more sure about what I wanted than I really was. So I did.
> **Elroi: How did you go about doing that?**
> Oh I just said, this is what I wanna do and I know it [laughs]. Whereas, I probably had a lot more internal dialogue than that, but I didn't talk so much about that.... I presented myself as being way more confident in my decision and what I wanted than I actually was.
> **Elroi: Did you feel like she wanted you to be confident in your decision, in order to give you the letter?**
> Yeah, I think she did want me to be confident in my decision, for sure. She wanted people to be sure that it was really what they wanted and it was right.

For guys like John and Zed, therapy served a distinct purpose in getting them access to medical transition. Although they knew they wanted to transition, they still grappled with anxiety around this serious decision. But they wanted to appear ready and willing to

start transition, and did not want to compromise their approval process by revealing any uncertainties about this process. These examples illustrate how some transmen submit to the discourse. Rather than expressing their doubts and risking authorization, they elected to reveal only the most certain attitudes in transitioning. As such, they submit to the discourse in these cases knowing full well that not doing so could have serious consequences. They did not want to risk being denied access to hormones, so they presenting themselves as secure and confident in their decisions. Another strategy of transmen in this sample involved the selective presentation of biographical information as represented by transmen who considered relaying a standard narrative.

Within the SOC, the HBIGDA outlines the history of nomenclature in treating transsexuals and traces the emergence of the notion of the "true transsexual" to clinical practices of the 1960s and 1970s (Meyer et al. 2001:3). The SOC explain, "True transsexuals were thought to have: 1) cross-gender identifications that were consistently expressed behaviorally in childhood, adolescence, and adulthood; 2) minimal or no sexual arousal to cross-dressing; and 3) no heterosexual interest, relative to their anatomic sex" (Meyer et al. 2001:3-4). In laypeople's terms, this authentic transsexual identity meant that a real transsexual likely felt born into or trapped in the wrong body since early childhood, and would pursue heterosexual relationships after transition. This powerful concept still influences transgender and psychomedical communities today. Many transsexuals relay this narrative of experience as their own or uphold it as the most telling characteristic of transsexual status (Mason-Schrock 1996). Interestingly, the SOC dismiss the concept of true transsexuals, pointing out that they rarely existed and some early gender clients fabricated these narratives to gain access to medical transition

(Meyer et al. 2001). "Belief in the true transsexual concept for males dissipated when it was realized that such patients were rarely encountered, and thatsome [sic] of the original true transsexuals had falsified their histories to make their stories match the earliest theories about the disorder" (Meyer et al. 2001:4). Thus, the clinical presentations of male-to-female transsexuals (MTFs) prompted health professionals to abandon the belief in a typical true transsexual. Those who were assigned female at birth did not affect providers' diagnostic processes because their "cross-dressing remained unseen by clinicians" and they conveyed "relatively consistent" histories (Meyer et al. 2001:4).[23]

This clinical history is important to consider because of the power of the so-called typical true transsexual narrative to influence present-day interactions between health professionals and their transgender patients. While clinicians have formally discounted this mythical concept for decades, transmen in this sample still believed that invoking such a narrative would garner medical transition quicker and more effectively. Like the early pioneers who sought to change their bodies to reflect their genders, transmen in this sample realized that they too could construct a narrative that would match contemporary theories about treating gender identity disorder. Many of these men recognized this narrative as a dominant discourse, and realized they could invoke it in order to gain speedier access to transition. With supporting data from this study, I argue that by describing eligibility criteria for transition services, the HBIGDA SOC represent the modern-day theoretical treatment protocol that transmen must negotiate in order to gain the bodies they desire. The SOC are documentation of the normalizing discourse. In transmen's pursuit of medical transition, they enter into a dialectical struggle with

[23] The SOC do no elaborate on this difference between MTF and FTM transsexuals. The vague wording in this section does not explain what is meant by "relatively consistent" histories and "unseen" cross-dressing practices.

psychomedical institutions that mandate validation, authentication, and legitimization before changing one's body. This struggle is regulated by an overarching desire to uphold the rules of a binary gender system, of which psychomedical institutions play a major role.

In this study, transsexual men sometimes constructed narratives to ensure approval for transgender services. By invoking trajectories of the "true transsexual," these men submitted to discursive tendencies that pathologize trans bodies. However, they purposefully manipulated the restrictive systems of psychomedical institutions to secure the physical attributes they desired, thus engaging in dialectic struggle for the autonomous body. As stated in the previous chapters, transmen were aware of this discourse and some felt prepared to invoke the "true transsexual" narrative in order to gain access to medical transition. They realized its usefulness in aiding their decisions to alter their bodies. While not all transmen needed to invoke this narrative, a few relayed experiences where they felt a need to describe more conventional journeys in starting hormones or getting surgery.

M&M started his transition about 20 years ago and described interactions with therapists where he felt like he had to present himself as a bona fide transsexual. While he appreciated aspects of a therapeutic relationship as beneficial, he resented having to go through it solely to get authorization. M&M understood the necessity of therapy "to a certain extent," but resented how therapists would typecast transsexuals in validating them and giving them "permission to do and be what you already know":

> I don't think you could typecast it. But back then you were probably trying to look for a particular person, had to say particular things. So that's always in the back of your mind. So oh my God, I'm not sure what they're lookin' for, but I hope I say whatever it is. It's like you have to authenticate that I am what I

> already am. That's just like to say, if we went into another world and I already know I'm black, but they have a list that says this is what black people do and say and be. And so, if I don't do that, I don't get my black card. [laughs] You know? That's the way I felt! Like, oh my God! I'm not gonna get my card.

M&M worried that his story would not count as valid and that he would not be able to get approval for transition. He described a specific interaction with a psychiatrist who his hormone-prescribing doctor required him to see even after he began administering hormones:

> He asked me basic psychiatrist questions about my childhood, my parents, and whether I had any mental illness in my family. You know, sort of standard.... I'm thinking, I saw *One Flew Over the Cuckoo's Nest*, I was thinking, people still *do* this? But he did this whole, really old-fashioned out-of-the-movies psychiatry evaluation. And he was writing feverishly as I was talking to him. And I remember not being free-flowing because it was just weird. So he would ask me something, I would sort of just tell him really quick, pointed sort of answers. There was moments of silence a lot of time because maybe he was waiting or trying to engage me, but I was thinking, I wasn't really sure why I was doin' that. I was feeling uncomfortable about the whole thing. He was classic textbook. This older guy with gray hair, I think he had his pipe in his mouth, it wasn't lit, but it was just hangin' there. And it was something like a dream. I'm thinking, oh my God, he's come out of my dream! But it was *weird*, then he started doing this ink blotter thing, and telling me, "What does this look like to you?" And I thought, oh my God, I know it's some classic question I'm supposed to answer. So everything started looking like a butterfly. Just butterflies, if I passed it.

In this experience, M&M had to talk with a psychiatrist and worried that his answers would affect his ability to continue receiving hormones. While M&M did not describe this process as relaying a particular narrative, he felt like he was being put through a test that he hoped to pass by explaining that all of the ink blotter images held in front of him looked like butterflies. He felt like he had to say the right things in order to get the card that authenticating his identity as a real transsexual. Interestingly, although M&M accessed transition so long ago, he believed that the hazing that transmen have to endure today is worse than what he dealt with in his interactions with therapists.

Adam's experience with a therapist employed a more direct approach to invoking a typical narrative. The chest surgeon he planned to use required a therapist's letter to perform the surgery. So in order to get approval for chest surgery, Adam went to a therapist with this specific purpose in mind. He would not have accessed this therapist if a letter was not required. He described their interaction as the only time he felt like he had to present a specific type of story in order to gain access to transition-related services:

> That was really the most, the visit to a health care provider where I most felt like I had to tell the right story in order to get what I needed. Because I wanted to, I had a very set goal in mind. I just wanted this one piece of paper. And I didn't want to do anything to raise his suspicions about me. And nothing that I told him was *false*, but I told my story in such a way that it highlighted my discomfort in my body when I was a teenager, which wasn't clear to me at that time that it was a gender-related thing. But I told the story in the way that made it sound like the signs were pointing to gender as the source of my problems.

Adam relayed selective biographical history that he believed would aid him in getting the letter of approval for surgery. He intentionally presented a carefully crafted narrative that resembled a more typical transsexual trajectory than what he actually experienced. He elaborated on this strategy:

> It was pretty much my strategy going in. I was sort of annoyed that I had to jump through that hoop anyway...because it didn't feel necessary for me. I understood that the surgeon was trying to cover his own butt in terms of the care that he was giving. But I wanted to make it as quick and painless a hoop as I possibly could. So, I consciously, [laughs] I tried hard to seem very well adjusted and did not dwell on uncertainties that I had. Or didn't really talk about the long period of time that I identified pretty exclusively as genderqueer, and really just focused on more traditional transition kinds of details.
> **Elroi: So if you had doubts, you weren't going to bring them up in this session?**
> Right, right. This was not a therapeutic relationship. It was definitely a means to an end.

In Adam's experience, he strategically employed elements of the typical "true transsexual" narrative. He submitted to this normalizing discourse because he wanted to get surgery. His experience illustrates the dialectical process. Adam submitted to the discourse that he thought the therapist expected, but articulated it consciously and strategically in order to prevent further barriers from him getting the body he desired. In presenting a narrative where he appeared more "well adjusted," Adam also employed strategies mentioned earlier in articulating his confidence in his decision to take this step in transition. Additionally, by omitting his experiences with being genderqueer, he recognized psychomedical institutions' stake in maintaining the gender binary and conveyed a history congruent with dichotomous understandings of gender.

One final case deserves mention. Jesse wanted testosterone, but did not want to be a man. In fact, he did not identify as a man and was not particularly invested in becoming what he described as "uber-masculine." Jesse described relaying his desired for a gendered body with his doctor. He was aware that his desires were atypical in that he did not necessarily embrace a male gender identity. Rather, he wanted the physical changes that hormones would bring.

> I do recall my doctor saying, "You're definitely one of the more different people than we usually see." Usually she would see people who were like, "I wanna be a man. I want to look as I feel and I feel male and I want to look male." When I came in there, I remember just saying, "I want a beard." And she's like, "So you identify with being male?" And in my head I was like, but if you say no to that, Jesse, then that will be really weird, so you should just say yes! So that you can get the hormones! [laughs] And I was like, "Well, I mean not *entirely*, but yes! Yes, I do, because I wanna take hormones." But I didn't want to have her think maybe I wasn't a good candidate for taking the hormones.

Jesse's experience relays exactly the process of invoking a specific narrative in order to procure transition services. He knew his identity and pursuit of a masculinized body was

atypical and that being honest about it could affect his doctor's decision to administer hormones. His thought process illustrates the dilemma he faced. He realized that if he told his doctor he was not male-identified and just wanted hormones so he could have a beard, then he could possibly be denied hormones for not presenting a typical transsexual narrative and for opposing the gender binary. Ultimately, Jesse communicated openly with his doctor, who recognized his decision as "unusual." She granted him hormones, a decision likely influenced by her employment within a queer-positive and trans-positive clinic in San Francisco that did not impose strict gatekeeping requirements. Jesse's revelation was heavily influenced by his desire to answer how he thought his doctor wanted him to answer. Such narratives pervaded transmen's interactions with health care providers.

Transmen in this sample reported relaying information that they believed their gatekeeping health providers wanted to hear. While they did not describe presenting specific narratives that reflected that of a "true transsexual," they described answering doctors how they thought they need to in order to access services. When Nate first tried to access testosterone, he reported feeling really uneasy when the doctor started asking him invasive and personal questions about his gender and sexuality. He described this doctor as "creepy" and explained how he dealt with the interaction in order to get hormones, "At that point, I felt like he had so much power over me, that I just tried to answer however I thought he wanted me to answer because I really wanted to get on testosterone. That was my ultimate *worst* experience." For Nate, his submission to a discourse was not explicitly in transsexual terms. Rather, he responded to this doctor based on what he perceived the doctor expected to hear. This exemplifies submission to

the normalizing discourse, or engaging in a dialogue that characterizes transsexual gendered pursuits as needing authentication in order to proceed.

As these data illustrate, transmen's submission to the normalizing discourse that pathologized transsexuals' pursuit of desired gendered bodies did not represent a process wherein transmen simply succumbed to the discourse without question. It was a dialectical process. This study did not detect any incidences where transmen engaged psychomedical gatekeeping institutions with total, uncritical submission. They did not simply go along with whatever doctors and therapists imposed, accepting diagnoses and internalizing pathology. Rather, their submission to the normalizing discourse was heavily informed by their necessity to do so in order to get the bodies they desired. They accepted the protocol as part of being transsexual, they viewed it as a means to an end, and they lamented the loss of agency in submitting to the discourse. In their interactions, they projected more confident selves, considered or invoked the typical "true transsexual" narrative, and answered however they thought the gatekeepers wanted them to. Thus, their submission did not embody powerlessness. They produced their own transsexual subjectivities, providing an empirical basis for the Foucauldian concept of productive power.

This dialectical process also included acts of manipulation of the discourse. This study demonstrates that transmen and their providers sometimes challenged the discourse and manipulated it to their advantages. While submission to the discourse sometimes included a critical analysis of the discourse, it left the discourse fairly unchallenged. Other examples from this study illustrate that both providers and transmen could manipulate the discourse to suit their end. Such experiences included cases where

transmen openly confronted power imbalances with providers, and when providers cooperated with their transmen patients in subverting the discourse so that it aided transmen.

Dialectical Negotiations of the Normalizing Discourse—Manipulation

Some transmen in this sample were so dissatisfied with the ways psychomedical institutions pathologized their experiences and desires for different bodies that they elected to manipulate the discourse. For these transmen, negotiating bodies within the confines of pathology entailed a process that transcended simple critical reflection or mimicry of conventional narratives. This arguably bolder approach included transmen who openly expressed their discomfort with the pathologizing discourse and psychomedical gatekeeping with the same health care providers that would confer or withhold services. In this way, these transmen risked losing authorization for transition.

Generally, the men in this sample viewed gatekeeping as something that happened *to* them. They expressed a sense of not being in control of their own lives and did not appreciate this predicament. As a strategy, a few men in this sample chose to confront this power imbalance with their gatekeepers. Trevor explained how he negotiated feeling uneasy about the power dynamic with his therapist:

> I went into my story, and she asked me a couple questions. And then I talked about how there is this power dynamic between her and me. We both knew that I wanted a letter at the end of three months. And I was really worried about being gay-identified, because I heard a lot of horror stories about people not getting letters because they weren't gonna make a happy straight person. And still feeling a little genderqueer too, not fitting the mold of masculine man. And after 30 minutes of our session, she told me that she was gonna give me a letter. And so that really helped with that. She just was like, "You don't have to worry. I've already decided that at the end of three months, you're getting your letter. So let's get to business."

Trevor's openness demonstrates his dissatisfaction with the way psychomedical gatekeeping affected his decision to change his body. By talking about this power imbalance with his therapist, he was able to manipulate the discourse. He refused to follow a typical "true transsexual" trajectory, risking possible rejection from obtaining a letter of authorization. Fortunately, Trevor's therapist graciously informed him that after he put his time in, he would get the letter. Trevor could not totally avoid the normalizing discourse; he still had to complete three months of therapy. But he was able to manipulate the discourse by expressing his discomfort with it. He was also able to talk about the ways the discourse can favor heteronormative and hegemonic masculinity in granting transition—a practice he objected to since he was gay-identified and still felt somewhat genderqueer. His resistance to gender profiling, then, also functioned to manipulate the normalizing discourse that contains his identity as disorderly.

Transmen in this sample were not the only actors who manipulated the normalizing discourse. They reported that some of their providers also willingly manipulated the discourse. Drew knew about some health care providers in Seattle that did not abide by the *Standards of Care*. He explained that his transmen friends in that part of the country do not deal with the same type of restrictive psychomedical gatekeeping:

> Their health care is real different out there right now. Their doctors don't even make you, like this one doctor [my friend] sees doesn't even do things based on blood work.... But she's seen enough guys to know that in conversation, she can kinda figure out where their levels need to be, 'cause it's really up to you.... In some ways they seem ahead of the game out there. Like, not treating every step with quite, under the microscope that we are down here.

Clearly, geographical region can play an important role in providers' attitudes toward and treatment of transsexuals. But accessing services in a large, urban environment does not guarantee more flexible guidelines, as seen in cases where transmen accessed services in an LGBT clinic in New York City. This study did not detect providers that behaved in the way that Drew described, but this form of manipulation is noteworthy. More commonly, the health care providers of transmen in this sample manipulated the discourse in concerted ways.

Health care professionals manipulated the normalizing discourse by colluding with transmen to get their care covered by health insurance companies. This manipulation involved cases where providers concealed overt transgender diagnoses and instead wrote testosterone prescriptions coded as other conditions commonly needed for nontransgender men. Adam explained his doctor's willingness to help her patients get the care they needed:

> I had heard that she was willing to give diagnoses that were not GID, if people needed to tell their pharmacy or whatever what they needed the testosterone for. I knew one guy who said that she had given him a diagnosis of hypogonadism, which is what nontrans men are often diagnosed with in order to be prescribed testosterone, which does not raise any flags for insurance companies. So, I had heard that she had given this other transguy that diagnosis to help him avoid raising the alarm with the insurance company. So I liked that she was willing to be creative like that.

This "creative" diagnosing was fairly common among the providers of transmen in this sample. Transmen often initiated this strategy to get coverage for care, and many of their providers were willing to bend the rules. This willingness to manipulate the normalizing discourse suggests that providers objected to insurance companies' treatment of transgender care as voluntary or cosmetic. They were willing to disguise diagnoses so that transmen could afford transition more readily. As Sam said, "It's just a game. They

get most of the money, and we have to play the game. So I play the game with my insurance company."

Another key way providers manipulated the pathologizing discourse was through negotiating the mental disorder of Gender Identity Disorder in writing the letter that would legitimize transmen for medical transition. Most transmen in this sample eventually found therapists who did not pathologize transgender experiences and identities. These therapists supported transmen in their decisions and did not ask them to defend their transgender identity. As Drew explained:

> My therapist never had any doubt in her mind that [transitioning] was exactly where I needed to go. She didn't encourage it, but she never even asked me. She didn't ask me to validate my identity. She didn't ask how long I had known. It just never was a question. It was kinda like this is who I am, that's part of who I am and it was good. And so to have that, almost *more* confidence from *her* than me at some times, was really helpful.... She was just a good support network. She never had any expectation as far as a time limit.

Kevin's therapist expressed similar support in his commitment to a trans identity, "He never restricted access; he was really supportive. And he wrote me a letter within a month to get hormones." For Drew and Kevin, the therapy process was not simply a means to an end. They each found therapy beneficial in dealing with their lives and impending changes. Their therapists aided in this process because they did not demand that these transmen defend their trans identities or decisions to alter their bodies through medical transition. Rather, they simply accepted their decisions and offered counseling around the issue without any kind of validation expectation. In this way, these therapists manipulated the discourse by refusing to abide by it. They did not interrogate these transmen about their life histories, making them justify what led them to embracing a trans identity. They offered support throughout their processes, and were happy to

provide them with letters authorizing hormones and surgery. The fact that they still had to write the letters meant that they did not avoid or transcend the normalizing discourse. They did, however, play the role that they had to play in order to aid their clients' transition.

Part of approving transmen for medical transition involved crafting a legitimizing letter that included a diagnosis of Gender Identity Disorder. In this study, some transmen said that their therapists expressed discomfort with using this diagnosis. These therapists disliked that they had to include a diagnosis of a mental disorder. Adam's therapist hid the fact that he diagnosed Adam with GID because of the stigma associated with mental illness:

> [My therapist] diagnosed me with GID, which I did not know until he mentioned it in passing during one of our meetings. He said something like, "Something, something—the diagnosis." And I was like, what diagnosis? And he said, "Oh GID." And I said, oh, I didn't know that you had diagnosed me with that. And he said he didn't always like telling people because he felt like there was this judgment implied, and so his pattern was not to bring it up. He made it into this little, almost like a little joke and it was actually very sweet because I felt like he had not wanted to hurt my feelings by telling me that he had made this diagnosis.

Based on the way Adam's therapist treated the GID diagnosis as a "little joke," it can be interpreted that the therapist disliked having to use it. Although Adam's therapist did not diagnose him with GID for the purpose of writing a letter, he still kept records on their interactions and felt bad about labeling Adam this way. On the other hand, Trevor's therapist did have to include that information for letter-writing purposes. She also joked about having to use that language and, as a transwoman herself, did not support it personally. Rather, Trevor's therapist only employed that discourse so that Trevor could transition:

> While she was writing [my letter], she was laughing about it. 'Cause we both could, I mean I think her being trans was really cool, we both could appreciate how ridiculous it sounded. That she was just apologizing, like "I'm really sorry I have to include all that stuff." And was kind of making fun of it.

This therapist clearly disliked the discourse that she had to invoke so that Trevor could access the services he needed to alter his body. She manipulated the discourse by expressing her disapproval of it to her client, but she still had to rely on it in order for Trevor to transition. She also included Trevor in the letter-writing process, making the process of authentication more transparent. This cooperative relationship enabled Trevor to enact agency in determining the contents of his letter. His therapist asked him what he wanted it to say, and they walked over to her computer to write it together. After writing the letter, she sent Trevor on his way.

Drew's therapist also felt troubled by the discourse. She believed the whole validation process was ridiculous, and expressed her dissatisfaction with it to Drew:

> I asked her, so what goes in this letter? I guess I was part of the process insofar as she told me about how she usually writes them. And what she told me was that she understands the importance of the letter, but she also feels frustrated in having to write one for the same reasons that I think I feel frustrated in having to get one. She said to me, "I'll include a few things in it about how long we've been working together." But she was like, "To be honest, when I write these letters I almost feel ridiculous." And I remember she said, "You wanna just say, 'He's a big boy. He's made a grown-up decision.'" [laughs] And she's like, "But you can't, so I sorta say that in my own way." And so she wrote it and then she said, "When I'm done writing it, you can come in and read it. And if there's anything that you're uncomfortable with or want me to change, then I will." And so, that's what we did. And it was fine. What she had done was fine and respectable and didn't offer anything that it didn't need to. And I felt good about it.

Drew talked about "the whole gatekeeper philosophy" in conversations with his therapist. He knew someone who had been denied a letter and vocalized his concerns to his therapist. Based on these conversations, he gathered that "she was not entirely comfortable being that person who approves or denies whether I can get this treatment or

not." While Drew's therapist wished that medical doctors just respected his wishes and granted him the treatment he wanted, she still had to comply with the discourse. She wrote Drew a legitimizing letter, and included the GID diagnosis in it. Drew disliked this process, but felt it was unavoidable. As he said, the whole process "sucks, but is what it is."

These therapists were extraordinary mental health providers in that they disagreed with the diagnoses and protocol that they had to follow in order for their clients to receive care and made sure their transmen clients knew where they stood on the issue. They manipulated the discourse by accepting their transmen clients' decisions without asking them to defend their choices. They also involved transmen in the process of writing letters and vocalized their lack of support for the way psychomedical institutions regulate transgender people's decisions to make gendered changes to their bodies. In these ways, therapists manipulated the confining discourse even though they could not avoid it. Transmen also manipulated the discourse by broaching the power dynamic issue with their therapists. But some transmen in this sample were able to access medical transition without adhering to protocols outlined in the *Standards of Care*.

Dialectical Negotiations of the Normalizing Discourse—Avoidance

Some men avoided the pathologizing discourse by pursuing their desired bodies through nonstandard methods. While no transman in this sample reported purchasing hormones illegally, a few found doctors willing to prescribe hormones without requiring therapist letters. A few transmen described getting hormone shots from friends, which aided in their masculinization such that they could continue it through their own

providers. These transmen avoided restrictive psychomedical gatekeeping, although it was not easy. Solomon had started getting hormones through a retired doctor that did not demand any legitimization. But when Solomon moved to Michigan and tried to continue getting T, he could only find a university research program that would do it. But as he said, "They wanted me to jump through all the hoops again. I was like, I'm not doin' that." So Solomon found a way to get "private testosterone."

As mentioned in the previous chapter, some men reported a lack of psychomedical gatekeeping in their interactions with providers. For some of these men, they intentionally sought care through these providers because they knew they could easily access hormones. But as mentioned in the previous chapter, ease of access sometimes compromised quality of care. This link between admissive psychomedical gatekeeping and transmen's avoidance of discourse illustrates that transmen were sometimes able to bypass restrictive psychomedical gatekeeping to transition. Total avoidance of the normalizing discourse, however, was not at all a common experience among transmen in this study.

Dialectical Negotiations of the Normalizing Discourse—Resistance

The dialectical processes of submission, manipulation, and avoidance of the normalizing discourse demonstrated the ways transmen negotiated psychomedical institutions in pursuing medical transition. However, many men in this sample vocalized great disapproval of this entire process. They did not support the ways the health care system pathologized their experiences and identities. Indeed, they often spoke out against these practices. This section demonstrates the dialectical process of resistance,

which differs from simple dislike of psychomedical gatekeeping in that transmen took an active stance opposed to the treatment they endured within these systems. Using a poststructural framework, it is important to understand resistance as occurring within existing power relations. As Foucault (1978) argued, "Where there is power, there is resistance" (p. 95). While Foucauldian concepts of power maintain that individuals can never truly operate outside of specific power fields, this understanding also pinpoints productive power as the mode of resistance:

> [O]n the topic of resistance, Foucault wrote, "as soon as there is a power relation, there is the possibility of resistance. We can never be ensnared by power: we can always modify its grip in determinate conditions and according to a precise strategy" (*Politics* 123). This comment demonstrates, first, *where* resistance takes place. For Foucault's subject, resistance is not to Power itself..., but to particular technologies of power, to specific strategies of social practices. Like power, resistance is a local event that must be concerned with the specificity of the practices in particular power relations. (Muckelbauer 2000:79)

Thus, resistance in this study was deployed in a number of ways within the disciplinary practices of psychomedical institutions and the normalizing discourse that regulates transsexual bodily desires.

One strong point many transmen made during this study was to emphasize that they were not crazy. These transmen felt insulted by getting diagnosed with a mental disorder and being required to go to therapy. They did not appreciate having their identities and experiences pathologized, and relayed their dissatisfaction to me many times. As Dave explained:

> They don't seem to realize nobody *chooses* this. This is not something you go, oh well, hoo! I'm gonna be trans today! We didn't ask for it, and they need to realize that. They need to realize this is just, they talk about people who have bipolar, they talk about people who, well this person's got this, and this person's got this. Okay fine, we've all got somethin'. Well they say we have *gender* disorder, now they say that's mental disease, right? Now we're all crazy. But we're not crazy. And there's a lot more of us than they think there are.

Dave strongly opposed having his gender identity thought of as crazy. Similarly, Zed stated, "I don't agree with the diagnosis [laughs]. I think that diagnosing people for who they are is sort of ridiculous." In this way, transmen like Dave and Zed resisted the normalizing discourse by asserting self-determination and autonomy in pursuing medical transition. Dissatisfaction with the diagnosis of GID was common among transmen in this sample. But some men hesitated to totally discount it because they realized that having a diagnosis could aid in getting insurance coverage for transition services. Getting insurance coverage for transition-related care was a priority for most of the men in this sample, but coverage occurred in complicated ways without uniformity.

Some transmen in this sample problematized the way that a mental disorder warranted coverage and believed their health care should be covered without accompanying psychopathology. Joey explained this dilemma:

> I don't think anybody should *have* to be diagnosed with Gender Identity Disorder. For me, this is a situation that needed to be handed with *my body*. I just can't understand the corruption of not having it covered by medical insurance. I just can't get past that. It's just very difficult to deal with, because it really feels like something that would greatly improve the quality of my life in a lot of different ways, not just sexually, emotionally, and physically. Totally.

For Joey, he located medical treatment on his body, not in his mind. He rejected psychopathology and emphasized that hormones and surgeries should be covered by insurance because they deal with changing the body to improve his quality of life. Drew detested that insurance coverage was based on gender identity and not on body parts, and felt dismayed by the way the pathologization of transsexuality connected to health care and insurance coverage:

> Being transgendered being viewed as a disorder is not going to help our cause anytime soon for it being covered by insurance.... If we were being viewed like

> anybody else, we'd be treated for our condition, to help us get to where we need to be.... I think this really exemplifies the problems within health care and within insurance. If you change your name and you change your sex, it changes your whole health care. And it's crazy, 'cause you're no longer treating the person; you're treating what *you chose* to be. So, if I changed my driver's license to male..., my health insurance will no longer...cover yearly gynecological exams. And if I did somehow get a doctor to code so that I could have a hysterectomy, it would not be covered under insurance. Whereas, if I changed my name but kept female, those things would be covered. And I just think that that's really screwed up, because who cares if my license says male? If I have those pieces and I have those parts, you should medically have to treat them. So, I think that what ultimately shadows over all of this is just the way that being trans is still viewed as a disorder and it's viewed as a mental health disorder and it's viewed as a choice. And so I kinda feel like you're being punished along the way. It's like, well *you chose* to do this, so you're gonna have to pay out of pocket for that, and you're gonna have to pay out of pocket for this.

For Drew, his health care had been affected tremendously by the way psychomedical institutions view his transition as symptomatic of a mental health disorder. Transmen like Drew and Joey vocalized their great dissatisfaction with health insurance companies' refusal to cover transition-related services. They viewed it as an injustice, and resisted the discourse that classifies the pursuit of transition as worthy of mental disorder and thus deserving of insurance coverage. But other transmen in this sample felt frustrated that they could not get coverage, period.

Some transmen in this study believed that their transition-related services should be covered under health care insurance regardless of disorder status. These transmen spoke out against the discourse that treated transsexual services as elective, voluntary, and cosmetic. They complained about high prices of surgeries and hormones. Solomon explained that he would like to be able to get a hysterectomy as a preventative action against cancer due to potential risks brought on by testosterone. While he felt hormone therapy was more affordable, he resented that insurance companies would not cover surgeries:

> For the uninsured guy, we can get the T, but then we don't get top surgeries, necessarily. And a lot of guys don't elect to get hysterectomies at all.... And these are the sort of things that should be covered by insurance. Anybody else, any straight person..., that would be considered cancer-preventative maintenance, particularly with someone with a history or a family history, that high risk of a category, their insurance is gonna pay for it right off the top, 'cause it's cheaper for them to do it that way than to pay for cancer treatment down the line. But when it comes to the trans community, they're like, "Oh it's benefiting your transition and we don't wanna pay for anything that might be related to you being able to change gender!" You know? [laughs] It's bullshit. It's medical negligence, in my opinion.

For Solomon, insurance companies refusal to cover surgeries was related to discrimination against any trans-related procedure. He believed that they would cover his hysterectomy if he was not transgender, but that his identity prevented them from offering assistance. In this way, Solomon resisted the discourse that relegated all transgender surgeries to an elective category that could not be covered by insurance.

This barrier to health care was frustrating for many transmen in this sample. Zed offered a different perspective for health providers to embrace. He explained that doctors should shift their thinking in dealing with trans people, in that the provision of medical transition delights trans people:

> Most doctors on a regular day deal with a bunch of people who are having all these aches and pains and stuff. But they can—and therapists, too—can really take somebody who doesn't really have anything physically wrong with them and through a few simple procedures or administrations of drugs, they're gonna be happy and smiling. So these health care professionals who might have somewhat of a glum job a lot of the time can really help people to achieve things for themselves health-wise that really make a huge difference in their life and that they're really happy about.

In his volunteer work educating health providers, Zed tried to spin transition-related care this way with hopes that they would embrace a paradigm shift in providing hormones and surgery to transgender patients. He resisted the discourse of pathologizing trans health

care. Instead, he offered a new way of thinking about these issues as granting transgender people a quality of life that they would appreciate amiably.

Other transmen in this sample resisted the discourse by pointing out that not everyone's transition follows the same path. These transmen lamented how psychomedical institutions viewed transsexuals' transitions as identical and expected them all to want the same changes in the same chronological order. When John compared the U.S. health care system to systems in Europe, he felt generally dissatisfied with the ways these systems tended to require transsexuals to follow particular transition paths, "In other countries, in a lot of ways that process is really fucked 'cause it's really focused on treating trans people like they have a psych disorder, diagnosing them with GID. And then going through this like, everyone's expected to want to have bottom surgery, and all this stuff." John did not value having his experiences pathologized or viewed as linear and uniform. As Sam explained, "You don't have to be transitioning from A to B or B to A. We're just people.... The bottom line is that all people should have access to *quality* health care." John and Sam resisted the normalizing discourse by stating that transmen's experiences with identity and desires for physical changes are as varied as transmen themselves. They resisted the discourse that believed all transsexuals were similar in their desires for bodies, and critiqued the way binary understandings of gender a sex framed the discourse.

Transmen's resistance to the normalizing discourse should not be understood as total objection to all aspects of the psychomedical institutions. Obviously, they must rely on these institutions to gain access to medical transition. They need doctors to prescribe hormones and to perform surgeries. But many transmen remarked that they also valued

their relationships with good therapists. These transmen stressed that while they did not believe therapy should be required in order to access medical transition, they believed in the general benefits of therapeutic interactions, especially during times of great change such as embarking on medical transition. While transmen like Dave resented the therapy requirement, they viewed counseling with a good provider as ultimately beneficial:

> It was an odd feeling to have to go see a psychiatrist, because I was, well there's nothing wrong with *me*. And then I thought, well, okay this is step one. Let's do step one and then we'll see what we can do about step two if there is a step two. But that was the first process in this, is going and getting *evaluated*—I guess would be a good term—to see if you *qualify*. Like I could apply for a job, you've got to be evaluated and then you've got to qualify [laughs]. But I think it's a good process because not only do the doctors get to know you, but they start pulling out stuff that might have been sunk for years. You really never really thought about prior to going in there, so it turned out okay.

While Kevin also felt resentful initially when he accessed counseling, he eventually grew to understand the requirement. But still, he could not offer total support for it as a requirement, and instead supported therapy because it had been so helpful to him personally. He explained, "I kind of understand why people might want you to go through therapy just because it changes *everything*. I don't know that it should be mandatory, but I would probably be in favor of it personally and if I were to talk to other people, I would recommend it, personally. I don't know if I could say *you have to do this*." For Kevin, transition brought so many changes that he truly appreciated having a therapeutic relationship within which to process his feelings about these changes. Drew also valued therapy generally, but felt conflicted about it as a prerequisite to medical transition. He described knowing someone who was denied a letter from a therapist and how he supported that therapist's decision:

> My friend and his friend were seeing the same therapist and [my friend] got an okay and this other guy didn't. It is an interesting situation, 'cause I kinda support

> the therapist's decision for this guy, at the time. He's a lot younger. He just hasn't—and this is where I can sit on both sides of the fence. I do. I think that it's definitely something that you shouldn't tell someone they can't do. And this guy wasn't even saying that, he was just saying he'd like to see him work through a few of his other issues that were very present before he went into that.... There's been times in my life where I don't think [transition] would have been a good decision. There's a lot of things that I had to do to get to the place where I thought it was a responsible time, whether I knew it was something I was gonna do or not. There were definitely more responsible times than others.... I mean, why add another thing that can be really confusing and really stressful on top of things that are confusing and stressful....? And I think that, that's the only reason I somewhat support this therapist's decision, 'cause this particular transguy was really just flying off the handle at the time.... But he left that therapist 'cause he was angry, and saw a new one and the new one put him on right away.

As the above quotation illustrates, Drew felt conflicted about the need for a therapy requirement. He acknowledged that there are better times to start transition than others, and realized the potential for therapy to help trans people choose the right time. But as he explained, even getting denied a letter will not stop a person who wants to transition from transitioning. In Drew's example, the transman that he did not believe was ready to transition simply accessed another therapist's services to get the required letter. So this transman was able to bypass the approval process by going elsewhere for care. Although Drew could sympathize with the therapist's decision, he still could not get behind a mandatory requirement for therapy. This experience demonstrates that even when presented with a more extreme need for therapy, some transmen will resist the normalizing discourse that requires therapy before medical transition. Transmen's general support of therapy does not compromise their resistance to the discourse. They could value good counseling while still resisting being required to go through counseling in order to transition.

Transmen's dialectical negotiation of psychomedical institutions demonstrates that they could submit, manipulate, avoid, and resist the normalizing discourse. At times,

health care providers also aided in manipulating or avoiding the discourse. These processes illustrate Foucauldian concepts of productive power. Each agent within the power field could resist the disciplinary practices of the field. The discursive power of the psychomedical regimes of truth can be seen in transmen's interactions within health care systems. Based on the pervasiveness of the normalizing discourse, transmen produce their own subjectivities in accessing medical transition. Discourse renders their pursuit of particular gendered bodies to a sphere wherein such desires occupy disorderly classifications. However, this strategic categorization ultimately reveals the inescapable and systematic regime of truth that ensnares everything—the gender binary.

While evidence from this study offers dialectical processes in negotiating medical transition and the normalizing discourse, the larger regime of truth of the binary gender system seems much harder to resist. Within the discursive power of the SOC, gendered paths are dichotomous and rely on binary understandings of sex and gender. Transsexuals must invoke narratives that reify binary gender. The SOC do not allow for changes to the body that transcend the gender binary. Rather, psychomedical institutions assume that each transsexual wants to move from one status to the "opposite" other in as many physical ways as possible. Thus, the gender binary that frames transsexual and nontranssexual pursuits and is the basis for these disciplinary practices is presently insurmountable. Non-dichotomous gendered desires do exist. For example, a female-assigned genderqueer-identified person may want to retain and display hir breasts while enjoying the masculinizing effects of testosterone. However, such desires become unintelligible within the pathologizing discourse that stakes claims in the gender binary. When psychomedical institutions continue to regulate non-normative gendered desires

within a limited pathologizing framework, such pursuits may only be legitimized in invoking the binary terms on which the discourse relies.

Chapter 6—Discussion and Conclusion

The research findings of this study reflect three main points. Transmen enter into health care systems as informed consumers. In pursuing medical transition, they interact within psychomedical institutions that largely pathologize their experiences and consequently impose different gatekeeping measures that transmen must negotiate in order to gain access to hormones and surgeries. And finally, transmen's negotiations within the confines of pathology represent a dialectical process that provides an empirical basis for major Foucauldian theoretical concepts.

Implications, Limitations, and Future Research

This research has serious implications for sociology, queer theory, and public health disciplines. It contributes to the sociology of gender, health, and the body. By situating these sociologies within medicalization, this research provides a useful perspective in understanding how psychomedical institutions regulate and reinforce socially constructed understandings of gender and the body. This work also contributes to queer theory in providing an empirical understanding of Foucauldian concepts by deconstructing the pursuit of transsexual bodies. Finally, the information about transmen's interactions within health care systems significantly contributes to the field of public health that lags behind in understanding nonclinical models of transgender experiences within health care systems.

As with any qualitative project, these research findings cannot be generalized to the larger FTM population. The sample of this study is also limited in terms of its diversity, especially in terms of race and age. The experiences of transmen of color need

better representation within research. Additionally, most of the men were new or young in their transition process, and the older, more stealth transmen were harder to reach and thus are not as represented in this study. Also, many of the transmen heard of this project through internet postings. Thus, the sample neglects to include those totally isolated from internet access. However, I believe this research offers important insights on transsexuality and medicalization previously unexplored in social research.

Another substantial limitation of this study is its exclusive focus on transmen. This research does not address the experiences of transsexual women at all, and I suspect their experiences within health care systems differ from those of transmen due to two chief reasons. Transsexual women typically do not pass as women as successfully or easily as transmen pass as men. Transwomen typically obtain a greater number of medical procedures than transmen, including facial feminization, tracheal shaves, and electrolysis. This disadvantage could produce significant differences in their interactions with providers, particularly concerning the gatekeeping practice of gender profiling. Indeed, research on workplace transitions confirms that transwomen encounter more penalties for embracing culturally devalued femininity, while transmen are rewarded for disavowing femininity (Schilt 2006). In addition, many transmen have come out within feminist and queer contexts. While no data support higher politicization among transmen compared to transwomen, I suspect that transwomen do not share such histories. Many of them transition later in life without being exposed to critical discourses on gender and sexuality that feminists and queer women encounter. This different coming out process could lead to greater internal pathologization among transwomen. They may internalize the normalizing discourse and lack the critical reflexivity demonstrated by many

transmen in this study. Thus, the experiences of transwomen within health care systems warrants further exploration.

Finally, one important area for future research would include the perspectives of health care providers. At times, I interpreted health professionals' actions indirectly as transmen relayed them. It would be useful to interview providers about their experiences with transsexual patients to further illuminate key findings in this study on gatekeeping processes. In a future project, I hope to take on these tasks.

Conclusion

When I first started this project, I expected to unearth a variety of inequalities transmen encountered in accessing and receiving health care. Indeed, my research did detect situations wherein transmen faced barriers to quality health care and insensitive providers. However, some transmen also experienced very little trouble within health care. Through grounded theory methods, I was able to locate the central theme of this project—psychomedical gatekeeping. By understanding why this process happened and analyzing when it did not, I was able to situate the data within a broader theoretical framework. By understanding how transmen negotiate bodies within the confines of pathology, I was able to illustrate the complex processes involved in accessing medical transition.

I consider it a regrettable reality that transsexuals must have permission to change their bodies (unless they manage to avoid gatekeeping or procure transition services illicitly). I think it is a great injustice to classify transgender experiences and identities as mental disorders. With a greater appreciation of gender diversity—including diversity in

gendered and sexed bodies—I think that transsexuals would be able to change their bodies without having to validate their identities, get authentication from therapists, and have their decisions continually legitimized by health care professionals. In societies that insist on dichotomous gender, the maintenance of two and only two gender and sex options produces the constant policing of transsexual bodies. As long as Gender Identity Disorder persists in restraining gender diversity, medical transition for transsexuals will rest anxiously within Western pathology. Perhaps one day Gender Identity Disorder will be replaced with Gender Binary Disorder. The disordering of dichotomies should be a prerequisite for validating, authenticating, and legitimizing all expressions of genders in identity and on the body.

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