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Spilling the T: Transmasculine Experiences with Testosterone Therapy

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Abstract

This dissertation utilizes a critical health psychology lens to document the experiences of transmasculine individuals with testosterone and gender-affirming healthcare. Semi-structured interviews were conducted with seven transmasculine participants who had participated in hormone replacement therapy for at least 6 months. Interview transcripts were analyzed using a recursive qualitative approach, resulting in nine themes: gaps in information about hormone replacement therapy; individual variability in hormone replacement therapy effects; complexity of nonbinary identity; barriers in the transition process; necessity and burden of self-advocacy; importance of community support; significance of sociopolitical context; impact of provider attitudes and education; and the need for holistic, individualized care. The study highlights the ongoing need for changes within healthcare systems in order to better support transmasculine patients. Results indicate that increasing provider education and awareness of these concerns could have positive implications for both the physical and mental health of transmasculine individuals utilizing gender-affirming care.

Keywords: transgender, transmasculine, gender-affirming care, thematic analysis

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Chapter 1

Background

The term transgender is used to describe a wide variety of gender identities and expressions. Individuals falling under this umbrella share the experience of having a gender identity or expression that does not fully align with the culturally prescribed gender presentation associated with their birth sex (American Psychological Association, 2015; Bouman et al., 2017). This group includes both individuals who identify within the cultural binary of male and female and those who identify outside that binary (Thorne et al., 2019) and are referred to in this paper as transgender and gender non-conforming (TGNC) individuals. Recent estimates of the size of the transgender population vary, with some reporting they make up as much as 0.6% of the U.S. population (Crissman et al., 2017; Flores et al., 2016; Meerwijk & Sevelius, 2017). Due to the difficulties in accurately collecting information about this population, however, these estimates are likely underreported, and the actual population may be even higher.

Gender Dysphoria

Gender dysphoria is often defined as discomfort or distress caused by a discrepancy between a person's gender identity and their sex assigned at birth/or current gender expression (American Psychiatric Association, 2013). The term is used to describe a diagnosable psychiatric disorder as well as a more general experience. While not all transgender individuals experience gender dysphoria, it can be debilitating for many. Individuals diagnosed with the disorder are at higher risk for poor social, economic, and psychological outcomes. They are more likely to experience stigmatization and discrimination; lower levels of education and higher rates of unemployment may lead to economic marginalization; internalized transphobia and social rejection may contribute to a negative self-concept and comorbid psychological disorders.

Psychological Health

Likely related to these systemic factors, TGNC persons tend to demonstrate poorer levels of psychological health and well-being than the general population. When looking at the Minnesota Multiphasic Personality Inventory-2-Restructured Form, Bryant et al. (2021) found that TGNC individuals scored higher on a majority of psychopathology scales when compared to the normative sample. Although not necessarily clinical elevations, the overall level of scores may indicate a higher baseline level of mental health burden compared to cisgender individuals (Bryant et al., 2021). Studies have shown an association between TGNC identity and higher rates of depression, anxiety (including social anxiety), and substance use (Butler et al., 2019; Valentine & Shipherd, 2018). Those on the transgender spectrum also tend to be less satisfied with their bodies overall (Becker et al., 2018; Kraemer et al., 2007) which may put them at higher risk for eating disorders (Ålgars et al., 2010; Witcomb et al., 2015). These overall higher levels of mental distress may contribute to elevated lifetime levels of non-suicidal self-injury, suicidal ideation, and suicide attempts compared to the general population (Reisner et al., 2015; Valentine & Shipherd, 2018; White Hughto et al., 2020). COVID-19 may have exacerbated these mental health disparities. Smout et al. (2022) recently found 73% of TGNC individuals surveyed scored above the clinical threshold for depression and 62% scored above the threshold for anxiety during the height of the COVID-19 pandemic, again displaying much higher rates than the general population for the same time period.

Mental Health Effects of Transition

Previous research suggests that gender-affirming healthcare may be one way to mitigate the effects of these challenges and benefits TGNC individuals in a number of ways. Although not all individuals on the transgender spectrum feel the need to change physical aspects of their bodies, some transgender individuals choose to seek out gender affirming healthcare in order to medically transition. This process involves using medical care to change their physiological appearance to be more closely aligned with their internal sense of their gender identity. This transition may involve hormone replacement therapy (HRT), as well as gender-affirming reconstructive surgeries (Chang et al., 2018).

Engaging in gender-affirming medical treatment is associated with better mental health and well-being in TGNC populations; Individuals who have medically transitioned in some way score lower on measures of psychopathology, including depression, social anxiety, generalized anxiety, and posttraumatic stress (Colton Meier et al., 2011; Nguyen et al., 2018; Tomita et al., 2019). Additionally, medical transition has been shown to be associated with greater body satisfaction and fewer eating disorder symptoms (Becker et al., 2018; Jones et al., 2020; Testa et al., 2017). Studies also show that medical transition is correlated with overall greater well-being (de Vries et al., 2014; Nguyen et al., 2018) and higher self-reported quality of life (Gómez-Gil et al., 2014; Gorin-Lazard et al., 2013; White Hughto & Reisner, 2016). The gender-affirmation process (including medical transition) has also been associated with a decrease in TGNC individuals' odds of contemplating or attempting suicide (Tucker et al., 2018; White Hughto et al., 2020).

Studies looking specifically at the possible benefits of HRT have also found a positive correlation between engagement with hormone treatment and mental health outcomes. One metanalysis found that hormone therapy was correlated with several benefits to TGNC individuals' health, including lower levels of gender dysphoria, better psychological functioning and quality of life, lower suicide rates, and higher rates of sexual satisfaction. (Murad et al., 2010). One study also found that participants showed significantly lower scores on scales measuring anxiety, depression, and overall psychological symptoms after 12 months of HRT (Colizzi et al., 2013). Achille et al. (2020) recently published a study looking at adolescents receiving endocrine intervention (puberty suppressing medications and/or hormone replacement therapy). During treatment, both depression and suicidal ideation decreased over time while overall quality of life increased. Another systematic review found associations between hormone therapy and less anxiety and dissociation, lower levels of perceived stress and social distress, and higher reported quality of life (Colizzi & Costa, 2016), although those assigned male at birth may benefit more than assigned female-at-birth patients in some areas, such as body uneasiness, emotional functioning, and personality-related psychopathology.

The Transmasculine Transition Process

The present study focuses on transmasculine individuals within the transgender spectrum. Transmasculine individuals were assigned the sex of female at birth but identify on the masculine end of the gender spectrum, whether or not within the binary (Chang et al., 2018; Hansbury, 2005). If transmasculine individuals choose to medically transition, HRT is often one of the first steps. Although the previous studies show that medical transition, including HRT, is associated with clear improvement in the mental health and wellness of transition-seeking TGNC individuals, the process itself includes physical and mental changes that can be difficult to manage. At the time of writing, there has been little research conducted looking specifically at transmasculine individuals’ experience of the challenges faced during the process of beginning testosterone treatment.

Masculinizing

As part of the HRT process, endogenous testosterone is prescribed and used to induce masculinizing changes in the bodies of transmasculine individuals (Coleman et al., 2011). For patients beginning testosterone treatment, physical changes primarily occur in the first 2–3 years of treatment, and it can take several months for any noticeable shifts in appearance to become apparent. Permanent changes resulting from testosterone include a deepened voice, enlarged clitoral tissue, increased facial and body hair, atrophy of breast tissue, and a change in the proportion of body fat to muscle mass (Chang et al., 2018; Coleman et al., 2011). Testosterone therapy may also increase transmasculine individuals’ lifetime risk for conditions like polycythemia, weight gain, acne, sleep apnea, hyperlipidemia, and possibly cardiovascular disease, hypertension, and diabetes (Coleman et al., 2011).

Sexual Behaviors

Additionally, transitioning transmasculine persons may experience significant changes in their sexual desire and habits. Researchers have noted an increase in libido, greater frequency of sex, a change in preferred sexual partners, or an increased interest in casual sex (Dadasovich et al., 2017; Garz et al., 2021). These changes can also coincide with physical shifts that affect sexual pleasure such as greater vaginal drying, increased risk of tearing, and differences in the frequency or experience of orgasms (Dadasovich et al., 2017). These shifts require transmasculine individuals to adjust to changes in their sexual identities and relationships.

Emotional Experiences

Testosterone therapy has also been linked to changes in emotional experiences and expression. Many individuals notice a change in their mood and may report mood swings, especially early in the process (Chang et al., 2018). Some transmasculine individuals report an increased feeling of emotional detachment after beginning HRT (Dadasovich et al., 2017). Although current research is limited and currently shows somewhat mixed results, there may also be a change in the way transmasculine individuals experience anger and aggression. In a recent research review on the connection between testosterone treatment and aggression, Kristensen et al. (2021) found that four out of seven studies included showed an increase in aggression-related constructs during the first 12 months of treatment. This may be indicative of a short-term change that may affect transmasculine individuals when beginning testosterone treatment.

Stress and Aggression

In line with the hypothesis of a short-term increase in aggression, the large shifts effected by HRT may make the beginning of a medical transition especially difficult for individuals to manage. For example, Matthys et al. (2021) measured the affective experience of transmasculine individuals starting testosterone and found a reduction in positive affect in the first 3 months of HRT, with another reduction between 3 and 18 months. This also coincided with a significant decrease in negative affect during the first year of treatment, which may be in line with the emotional detachment mentioned above. Another study measured higher cortisol levels in transmasculine individuals experiencing transitioning-identity stress (stress related to having a socially and/or physically ambiguous appearance because they are in the hormone-induced transition process). This ambiguity in gendered appearance may lead to more experiences of discrimination and rejection and higher levels of overall stress for transmasculine individuals during the beginning of HRT (DuBois et al., 2017).

Stigma and Discrimination

External stigma and discrimination also have an effect on the health of TGNC individuals and is relevant in the discussion of transmasculine transition. TGNC-identified people report higher rates of housing and employment discrimination than cisgender individuals, even if cisgender individuals self-identify as LGBQ (Kattari et al., 2016). The COVID-19 pandemic may have exacerbated these disparities. Smout et al., 2022 found that around one third of surveyed TGNC individuals experienced a negative change in employment since the pandemic began, a rate substantially higher than the general population during the same period. Those experiencing changes in employment were also more likely to report difficulties with housing. Those identifying as TGNC also report higher levels of discrimination within healthcare systems. In one study on health care discrimination, TGNC participants indicated approximately 42% had experienced verbal harassment, physical assault, or denial of equal treatment in a medical setting (Shires & Jaffee, 2015). In another study, Cruz (2014) found that as many as 50% of TGNC individuals delay seeking needed medical care, with around half of those respondents naming discrimination as the deciding factor. Because of the ignorance and discrimination, they often face in healthcare settings, TGNC individuals often learn to conduct their own research and find creative ways to advocate for themselves in order to meet their needs. They often face a high burden of care, utilizing multiple strategies to navigate healthcare systems in the face of discrimination and stigma (Roller et al., 2015).

Minority Stress Model

Recent research applying the minority stress model to TGNC populations indicates a possible reason for the gap in psychological and health outcomes. Experiences of stigma and discrimination are associated with poorer mental health outcomes (Bouman et al., 2016; Pellicane & Ciesla, 2022). Within the TGNC population specifically, expectations of rejection and internalized homophobia have been demonstrated to be associated with higher levels of depression and suicidal ideation (Pellicane & Ciesla, 2022). This effect may be even larger for those with other intersecting minority identity markers (Farvid et al., 2021; Hendricks & Testa, 2012; Pellicane & Ciesla, 2022). College students with intersecting identities as both gender and sexual minorities had significantly worse anxiety and depression outcomes than those with only one (Borgogna et al., 2019). Both White and non-White TGNC participants in one qualitative study also reported that people of color experience higher levels of stress related to the expectation of rejection because of the added element of racial discrimination. (Rood et al., 2016). These effects are not limited to mental health. Flentje et al. (2020) noted a connection between minority stress and poorer physical health outcomes in sexual minorities. Newer research is also being released indicating health disparities specifically related to stress and stigma among the TGNC community (Veale, 2023).

A Critical Health Approach

Transmasculine individuals seeking HRT are obligated to work closely with medical practitioners and often with mental health professionals, as well. Often, TGNC patients are required to obtain a letter from a mental health practitioner showing that they have a documented experience of gender dysphoria, that any significant medical or mental health concerns are well-controlled, that they are able to give informed consent for the treatment, and that they are prepared to manage the expected changes (Coleman et al., 2022). However, in recent years concerns have been raised about this process due to the pathologization inherent in the requirement for a gender dysphoria diagnosis and the possibility of the assessment being used as gatekeeping (Schulz, 2018). This process may be especially problematic because many providers (both psychological and medical) remain ignorant about or uncomfortable working with patients who identify as TGNC. This often leads clients to feel misunderstood (Grant et al., 2021) or be met with the need to educate their providers about the process and their needs (Forsberg & Eliason, 2022).

The positivist approach, often seen as foundational to the field of psychology, focuses on universals and "standardized laws," with strict definitions of health and illness typically defined by those with the most power (Murray, 2015). Those working in health psychology have frequently adopted goals from the biomedical model, such as mitigating costs and maximizing benefits, controlling health behaviors, and prolonging life. Much of the current research on transgender health has come from this framework and seeks to fit the concerns of TGNC patients into the existing model. However, as one researcher says, "this focus on the body… may be dismissive of transmasculine individuals' identities and experiences, as these studies typically fail to center the voices and experiences of transmasculine individuals" (Pulice-Farrow et al., 2021, p. 383).

In contrast, critical health psychologists take issue with the often reductionistic and instrumental view of healthcare. Healthcare professionals and researchers have assigned a specific approach to the process of studying health, but by reducing our frame in this way, health psychologists may be missing other socially and morally important aspects of wellness and illness as well as objectifying and depersonalizing patients (Crossley, 2008). Critical health psychology challenges the common approach to research and questions whether the focus on quantifying concepts has come at the expense of devaluing lived experience. Researchers seek to look at patients in their social and historical context, including an understanding of social inequalities in health (Murray, 2015).

For many critical health psychologists, the goal is to work with oppressed or marginalized groups to increase understanding of their experience in order to develop a more endemic approach to promoting health in those groups. The researcher seeks a reflexive understanding of the way their role and values may affect the work, seeking to ensure its benefit for the population being studied. Topics are often approached through experiential research. Research participants are considered experts on their own experiences. Therefore, methods are chosen to allow participants to describe their experiences in a manner that feels meaningful to them. This allows the research to spotlight often invisible experiences and to expose diversity, rather than collapse it (Murray, 2015).

If psychologists are to be so integrally connected with gender-affirming healthcare and the process of medical transition, it is important to make sure the foundational research and resulting clinical recommendations will reflect this population’s experiences without the researcher dictating, narrowing, or possibly missing them. Thus, this study seeks to fill a gap in the existing literature, which has been most often approached the study of HRT from a traditional biomedical frame. The goal of this study is to document the experiences of transmasculine individuals beginning testosterone treatment and utilize a critical health lens to explore their understanding of the process, the challenges involved, and needs they may have. This information will provide healthcare providers with valuable information needed to better support this population.

Chapter 2

Methods

Participants

The study design was approved by the Institutional Review Board at George Fox University. Participants were recruited virtually by convenience sampling utilizing flyers, listserv posts, and community referrals. Volunteers were directed to a sign-up form created with Google Forms. Participants were required to be at least 18 years old, assigned female at birth, and to have experience taking testosterone for at least 6 months as part of a gender transition process. The initial participant pool included eight individuals, but one participant’s interview data was lost, resulting in a final participant pool of seven (*n*=7) individuals. Demographic information was collected as part of the study (see Table 1).

Table 1

Individual Participant Demographics

Participant	Age	Sex at Birth	Gender (in participant's own words)	Race/ Ethnicity	Education	SES
Participant 1	21	Female	Genderqueer Transmasculine	White	Associate's or Trade School	Lower/Working
Participant 2	25	Female	Trans-Nonbinary Agender	White	Master's Degree	(Not reported)
Participant 3	24	Female	Nonbinary	Middle Eastern	Master's Degree	Middle
Participant 4	28	Female	Genderqueer	White	Doctorate	Low/Poor
Participant 5	36	Female	Trans man	White	Associate's or Trade School	Lower/Working
Participant 6	46	Female	Transmasculine	White	High School	Middle
Participant 7	41	Female	Transmasculine nonbinary	White	Bachelor's Degree	Lower/Working

Note. SES = socioeconomic status.

Materials

Demographics

A short questionnaire was developed to gather demographic data. Participants were asked to provide their age, race/ethnicity, gender identity, gender assigned at birth, sexual orientation, relationship status, education level, employment status, and types/length of gender-affirming healthcare. This questionnaire was administered via Google Forms prior to participating in the interview.

Semi-Structured Interview

A semi-structured interview informed by a review of current literature was created to guide discussion (See Appendix C). Each interview was audio recorded and transcribed verbatim.

Procedure

As part of the volunteer process, participants were provided with information about the study and were asked to sign a detailed informed consent (see Appendix A) to volunteer. Participants were provided with the opportunity to schedule an interview appointment directly through an online scheduling platform or to coordinate with the principal researcher (PR) via email or text. They were sent follow-up reminders and a request to complete the demographic survey via email. All interviews were conducted virtually. Participants provided additional verbal consent at the beginning of the interview and were provided with the opportunity to ask questions about the informed consent document, study design, and process. Interviews lasted approximately 60–90 minutes per participant. Conversation was guided by a semi-structured interview (see Appendix C) with process-oriented follow-up questions determined by the PR. For the purposes of analysis, each session was recorded. The recordings were stored on an encrypted, password-protected computer and transcribed utilizing Health Insurance Portability and Accountability Act-compliant medical transcription software.

Data Analysis

Following the interviews, data was analyzed utilizing recursive thematic analysis based on the work of Braun and Clark (2022). Deidentified transcripts were coded for thematic content utilizing qualitative analysis software (i.e., Dedoose) and then analyzed to identify themes related to research questions. In line with the critical health psychology framework, this method was to analyze data without trying to fit it within a pre-existing framework, but to instead provide an accurate representation of participants' narratives. Following the interviews and data analysis, results were then additionally assessed for accuracy utilizing member checking (McKim, 2023) to ensure that results of the analysis align with the perspectives of the population being studied. Member checking was conducted via email utilizing pre-determined structured questions (see Appendix D).

Chapter 3

Results

As stated above, the purpose of this study was to explore transmasculine experiences with testosterone and gender-affirming healthcare and document their understanding of the process, challenges involved, and ongoing needs. For the most part, participants' descriptions of the changes they experienced when starting testosterone aligned closely with current research and medical advice. Most people named physical changes such as increased muscle mass, change in fat storage, bottom growth, increased hair growth, and voice deepening. Many also noted an increase in their sex drive. Additionally, aligned with research described above, participants reported improvements in mental health and fewer struggles with gender dysphoria after beginning testosterone. Therefore, rather than simply describing these results, the PR chose to focus the thematic analysis on more nuanced themes, which were primarily centered on participants' experiences with healthcare. The process revealed nine themes directly relevant to research topics: (a) gaps in information about HRT, (b) individual variability in HRT effects, (c) complexity of nonbinary identity, (d) barriers in the transition process, (e) necessity and burden of self-advocacy, (f) importance of community support, (g) significance of sociopolitical context, (f) impact of provider attitudes and education, and (g) the need for holistic, individualized care.

Gaps in Information about HRT

The majority of those interviewed stated that they felt providers did a good job of educating them and preparing them for these changes. However, there were two areas that were consistently named as gaps in the provided information: reproductive and sexual health and psychological effects.

Several participants pointed out that information related to changes with reproductive organs, genitalia, and fertility did not adequately prepare them for the changes they experienced. Participant 2 indicated that the only reason they knew about the potential for vaginal atrophy was because of information gained from other TGNC people:

> The one thing that I would say that they do maybe neglect to talk about is that I don't think either of the times that I started HRT that vaginal atrophy was talked about. That's a change that for some reason doesn't seem to get discussed as much. … So I don't know that if I hadn't talked to other trans people that wasn't something that I would know it was something that could potentially happen.

Participant 4 said they were told they would stop menstruating but were not warned about the potential for irregular bleeding with testosterone. They shared, “the amount of random spotting and bleeding that actually does happen. That is something that because if you don't know it could happen, it's terrifying when it does, so more information on that would have been helpful.” In addition to overlooked information in this area, some participants mentioned experiences of receiving mixed or inaccurate information, especially related to fertility and birth control.

Similarly, participants stated a need for more education provided about the effects of HRT on sex and sexual health in general. Participant 3 shared that they were completely unaware of that testosterone could affect their sexual experience, saying “I didn't know that, um, having sex would change for me, which I guess should be a duh. But it wasn't a duh. I didn't think that. Yeah. I didn't know again.” Participant 4 spoke about the impact of vaginal atrophy on sex:

> I think there is a lot of lack of information about how it can impact kind of sex in general. … Literally learning through like Reddit or research, research articles about like women

> who have gone through menopause is actually that is some of the better recommendations.

Participants also commonly noted a lack of adequate preparation for the psychological effects of testosterone. Although providers often gave detailed and accurate information about the physical changes expected with HRT, the effects on mood and mental health were sometimes overlooked. Participant 7 stated, “All of the physical stuff, like the physical effects from it were, were accurate to my recollection. I do note that they didn't include anything about psychological stuff and like that.” Participant 1 spoke of being somewhat blindsided by the emotional changes when they happened:

> The doctors and stuff told me about what I can expect on testosterone, they never really talked as much about the emotional changes that I could expect. So it kind of, it felt almost like it came out of nowhere and I'm like, there's no guidebook on how to deal with this.

There also seemed to be a lack of consideration about how the testosterone may interact with other aspects of a patient’s psychology or mental health. As an example, providers sometimes failed to consider the effects of testosterone and how it may impact psychological conditions like bipolar disorder. There also appears to be a need for more research on the effects of HRT on those who are neurodivergent. For instance, Participant 2, who has autism spectrum disorder, spoke of the effect testosterone had on sensory sensitivity: “I found myself a lot more sensitive to like sensory input and getting frustrated by that a lot faster, getting overwhelmed a lot faster.” Participants indicated the benefits of being better prepared for these types of experiences. In addition to patient education, providers may be able to better support TGNC patients beginning HRT by coordinating care in order to monitor psychological conditions more closely, make adjustments to psychotropic medications, and utilize therapy to increase psychological and social supports.

Individual Variability in HRT Effects

Another common thread in participants' statements was the importance of providers recognizing and educating patients on the individual variability in the effects of HRT. While the information shared above demonstrates the importance of providing extensive and accurate education about the process so that patients can be prepared, participants also shared that it was helpful for providers to help them manage expectations about the effects of HRT. Participant 3 said,

> I would hate for a provider to tell me, oh, you will definitely get a full face of facial hair. But that hasn't happened for me. My facial hair sucks. So, I guess, just being transparent with the things that they do know but also being open to the fact that testosterone affects everyone differently.

In addition, participants appreciated it when providers tailored information to help them know what to expect. For example, it was helpful for providers to ask about a history of male pattern baldness in the family to give the patient a better idea of how likely he would be to experience this. This was also relevant to more significant health conditions. Participant 1, who experienced serious uterine/ovarian problems after beginning HRT said that providers did not ask about relevant family history that may at least have led to a quicker diagnosis. He stated, "I think the whole, if you have a family history of uterine or ovarian issues that your reproductive organs might try to self-destruct from testosterone. It'd be nice to know."

Given this variability in effects, participants also noted the importance of providers being flexible in their approach to HRT. Multiple individuals noted the importance of finding the right dose for each individual. Participant 2 struggled with side effects on their initial dose, and stated,

> I had asked for low dose and that's what they said it was. But in retrospect, especially now that I'm back on HRT I have a better idea of how I [respond]. I think for me, it was a regular dose.

Participant 5 noted that providers should be open to patients making adjustments in the process after they see how testosterone affects them. He shared how he would like providers to address this with patients: “These are the typical results and effects that can happen but hormones are gonna [sic] be hormones and react with your body on a very individual level … That disclaimer that the typical may not be the right for you.”

Complexity of Nonbinary Identity

The majority of participants noted that they identify more with labels such as nonbinary transmasculine or genderqueer transmasculine rather than within a strict binary. They discussed ways in which this aspect of their identity has affected their transition process within the binary-focused U.S. culture. In discussing the complexity of their intersectional identities, Participant 3, who is Middle Eastern nonbinary transmasculine, noted the influence of culture on views of gender: “I mean, I guess everywhere there's history of gender fluidity in like all cultures but right? … I feel like the idea of a binary gender is sometimes rooted in western colonialism, stuff like that.”

Several participants indicated that the cultural bias towards binary gender presentations affected the way they chose to socially and medically transition. They noted pressure to stay within binary expectations and the necessity of having to choose the binary presentation that felt more accurate, even if it does not fully represent their identity. Participant 4, who identified as genderqueer transmasculine stated, “I would probably play a little more with my presentation and be more diverse in how I present. But here I kinda have to double down on being extra transmasc [sic] because otherwise I'm just a woman in Texas.” Participant 5 shared,

> And so, at the time I'm like, well, you know, I would probably identify as nonbinary if I could, you know, socially be accepted as such, right? And especially in the Midwest, it was not gonna [sic] happen. So now it's kind of the second round where I'm like, OK, but now I'm being perceived as male, which is better than how I felt, being perceived as a woman. But it's still not exactly accurate.

Other participants indicated that gender-affirming healthcare is often very binary-focused. Some spoke of additional considerations when choosing healthcare, such as Participant 2, who spoke of the extra time and effort to find transition options: “the requirements for health insurance coverage were … very binary and I didn't feel that those are requirements that I could meet. So I've generally sort of waited until I found an informed consent option and gone for that.” Another participant mentioned hearing of providers discouraging nonbinary individuals from pursuing medical transition, stating, “I've known other nonbinary people who've been told by practitioners, why would you want to transition like, you know, things like that and really trying to maybe scare them away from it.” Participant 7, who identified as nonbinary also noted the medical bias towards binary care but stated that it did not bother him as long as he could access the care he needed:

> They see me or they presume that I'm a trans man and that I get the health care that a trans man would typically get. And they don't necessarily need to know that I feel

> nonbinary. I don't know. As long as I'm getting the health care that I need, I like, I don't really, it doesn't matter if I share it.

However, he also stated that it was important for *mental* healthcare providers to take more care in understanding his identity rather than assuming a binary gender.

Barriers in the Transition Process

Participants named multiple systemic barriers that impacted their transition process. The most common barrier encountered by all the participants related to the financial burden and the difficulty of finding insurance coverage that would pay for gender-affirming care. Even when no other barriers were mentioned, financial considerations were still named. Participant 7 stated, “I don't feel like I've had many barriers at all. Aside from the financial thing. Here's my privilege.” Participants named that accessing HRT is much cheaper and often more accessible than other forms of care such as surgeries, as Participant 5 said,

> So getting top surgery, the deciding factor with that was financial … I wanted top surgery before I started hormones but hormones are way cheaper. And like no insurance covered trans surgeries. So I, it took maybe five to eight years before I was able to figure out top surgery.

However, financial barriers were still a consideration when discussing access to testosterone, as Participant 3 said, “I'm also very lucky that I, I'm able to afford testosterone just like, in this economy and all that.”

Related to the financial burden, participants shared that insurance coverage was another important concern. For some, the lack of insurance led to delays in the process. Others named the frustration involved in the process, such as Participant 1, who stated, “But yeah, this is a long process. It's really frustrating because they kept, cause there's all just like so much bureaucracy and it's like the insurance wanted to turn it down.” Participant 6, whose difficulty finding the right dose led to additional side effects, also shared, “So my dosage got kind of messed up because I started on a topical. And then because of insurance complications and finances … I started on a cream, then I switched to a gel and then I went to injections because it was cheap.” Even when participants were able to find needed insurance coverage, any change in life circumstances could threaten the affordability or quality of their care. Again, Participant 6 shared their worry:

> There’s a potential that we might have to shift insurance um in the next few months or coming months. And I didn't realize how anxiety provoking that was going to be for me because I'm, I'm now well established in my medical support network. And the idea of maybe like not being able to see those providers is alarming.

As the last quote indicates, another common barrier mentioned by most participants involved the difficulty of finding providers who were willing to prescribe and/or monitor hormone therapy. Successfully accessing care can involve perseverance and the ability to “jump through hoops” required by insurance companies and physicians.

This barrier was often tied to geographic and transportation factors. In the U.S., gender-affirming care can vary greatly from state to state and several individuals shared that geographical location impacted their access to HRT. Participant 4 stated, “So to get on HRT I actually had to drive to [another state]. Oh, because the Planned Parenthood here, uh, was not able to prescribe it due to like some weird municipal laws in [southern state].” Participant 1 shared that,

> I tried to initially start on testosterone then. But I was living in [western state] and we only had, like, one doctor's clinic and I talked to them about it and the doctor, … she's like, I won't prescribe you testosterone. Now, you have to go to the city for that.

These barriers lead some to move to certain areas in the hope of increasing access and even led some individuals to consider alternative ways to access treatment, as Participant 3 said, “Because when I was home, my home is [northeast city]. Yeah. So I just really couldn't find anywhere to get hormones and I was like, should I just go on Craigslist?”

Although the challenges and barriers described above were widespread in participants’ narratives, some participants also named factors that reduced barriers and increased their access to care. Just as some folks named geographic location as a barrier, it could also be a benefit. Participant 3 stated, “I think being in [western state] made this process a lot easier.” Others named specific systems or types of medical care that increased their access, such as university healthcare clinics, Planned Parenthood, and online prescribers. The same participant also stated that, “My school literally had a gender health clinic where they just would set me up with that sort of gender-affirming care. Yeah, without asking too many questions.” Participant 5, who is in his 30s mentioned the increase he has seen in provider accessibility: “So early on in my transition since there were so few providers who would even touch trans care in any sense. Yeah. But that's come a long way, which is really great.”

While some participants’ stories illustrated the increase in accessibility over time, there still appears to be significant systemic barriers to accessing care. Intersectional identity may play a role—participants of higher socioeconomic status and participants who “pass” as White, cisgender men indicated fewer barriers. Ongoing cultural and political conversations in the U.S. may also play a large role in either increasing or decreasing these barriers moving forward.

Significance of Sociopolitical Context

Participants spoke about specific impacts on their process related to the current social and cultural context in the United States. These factors included specific current events such as the impact of COVID-19 and current political narratives as well as more general cultural attitudes towards gender and identity.

When asked about the impact of COVID, participants were split as to whether or not it affected their transition process. Two participants indicated little to no impact. Participant 6 stated, “Yeah, it, it didn't, I mean, I remained employed full time. I had access to my medications.” Other participants, however, mentioned an impact on their ability to access healthcare. Participant 1 stated, “It definitely just like slowed things down and it made it … harder to go get things that had to be in person, like blood work and stuff done.” Several participants mentioned these barriers lead them to miss doses or even discontinue HRT. Participant 4 noted that,

> because they also wanted blood work, they were kind of backed up because there were such strict regulations on going into the hospital that there was a lot of delays and things like getting my prescription late because of some of these things. So missing a few weeks [of testosterone].

Participant 3 put it very succinctly: “yeah, COVID made me have to stop taking it.”

In addition to the difficulty accessing medical care, two participants noted the psychological impact of the pandemic and its effect on their transition process. Participant 4 noted that the lack of community affected their adjustment, saying “So definitely the community isolation was pretty significant and made the process, I think a lot harder in terms of mental health and kind of how I thought about myself.” Participant 5 indicated that the impact on his mental health led him to miss doses of his medication: “In the beginning of the pandemic was actually one of the times that I stopped doing my hormones and that lasted quite a while. … And that was more like mental health related.”

Prompted by the interview question, all seven participants shared added emotional burden related to the current political climate in the U.S. Many also named concern about the effects on future access to gender-affirming healthcare for themselves or their community. Participant 7 summarized that, “it's a bit anxiety provoking with all the anti-trans laws that are coming out. I have an underlying fear that there's gonna [sic] be something like national gender care ban ... and makes me nervous about getting access to my medications.” Participant 2 mentioned this fear leading to an acceleration of their transition timeline, saying “seeing both sort of trans healthcare and reproductive healthcare being restricted and kind of generally under fire, that sort of put a little bit of a fire under my ass.”

Several participants mentioned the impact that news and media has on their experience, but participants differed in their personal responses. Participant 6 mentioned the need to limit media exposure:

> I have some exposure to news, which is important to me. But it's, it's relatively minimal. … I currently struggle with strong feelings that it's just a big pile of burning shit. Like, yeah, like in the world is just a big ball of burning shit. And I am trying to challenge myself to find some joy and to some extent that is like, makes my world a lot smaller, like I've had to like shrink the amount of input.

Another (Participant 5) shared about seeing a news story about an assault on a TGNC person and how it reinforced the need to support one another as a community: “you are terrified to open it because the chance is high that you know who it was. … just check on your people. Keep them close and, uh, it's always close to home."

Necessity and Burden of Self-advocacy

In line with other research (Roller et al., 2015) showing the burden on transgender individuals in navigating healthcare, most participants noted that they did their own research before seeking gender-affirming care. Participant 5 shared, "I went into my first appointment already with a vast amount of knowledge. [The provider] wasn't presenting anything that I hadn't already read or understood already." Others pointed out that this research feels like a necessity rather than an option in order to receive quality care. Participant 2 noted, "I don't feel like as a trans person that I could necessarily, you know, walk into any doctor's office or have any PCP and expect to get the same level of care as a person without doing any research."

Multiple individuals mentioned relying on this research to advocate for themselves with providers and guide their care. Participant 6, who experienced problems after starting with a testosterone dose that was too high shared how they relied on their own research to guide treatment: "we checked blood levels, we did the stuff that I knew about to be safe. But he also, I had done a lot of research. I had asked questions that if I hadn't asked them, he didn't provide that information." Another noted the need to self-advocate with a mental health provider for help with mood regulation as he went through the transition process. Participant 1 stated, "Once I brought it up … I also was able to go to my counselor and be like, 'hey, can we find coping skills and things that like maybe when I'm quick to frustration to calm me down from that?'"

While acting as drivers of their own care seems to be a widespread experience, this necessity places the load on TGNC individuals to know how to access information and to invest the energy into self-advocating and educating providers. This places additional burden and stress on individuals accessing gender-affirming care. Participant 7 said,

> It's an unnecessary stress. Cis straight or cisgender people don't have to think about that necessarily because any gender care they get is not ever going to be a problem, you know. So, oh, your testosterone is low. Here, have some more testosterone. And you don't, you don't have to worry about this ever getting taken away from you.

Participant 6 straightforwardly stated, “I want medical professionals to know that it's exhausting to constantly have to advocate for ourselves with professionals.”

Importance of Community Support

Closely related to this idea of relying on personal research was the importance of the transgender community in the transition process. All of the participants mentioned the importance of community in some way, and most of them indicated a reliance on community contacts to find healthcare-related information and resources.

A few individuals noted the importance of community as support while exploring their identity and deciding to transition. Participant 7 shared about reconnecting with a friend, “I sought him out for the purpose of asking him questions about his transition. And he was super supportive and it was shortly thereafter that I made the choice to seek medical transition.” Participant 5 spoke more generally about his friend group:

> I was really fortunate to have that friend group because, you know, they all had their own experiences with it too. And I did there was trans masculine support group that we went to a couple of times. And just kinda [sic] the typical queer create your own chosen family, find your network, find your support groups.

Although most participants noted the benefits of connecting with other TGNC people, Participant 4 noted that their lack of community support as they went through the transition process almost led to detransitioning: “I was to the point where I kind of thought I needed to detransition even if I think that's not at all how I actually feel.”

In addition to this more general support, several participants noted the importance of communication within their community for sharing resources and finding competent providers. Participant 5 shared about the difficulty of finding insurance coverage for surgery and how community connections helped, stating “I ended up, there was, I had a friend who was working a job and their company's insurance covered surgery. So I got in at that job and got surgery and then left that job. We work the system.” Participant 6 also explained that the information shared within the community is often more trustworthy and easier to access than trying to find resources in some other way:

> But I'd still, I mean, if I had to change doctors now, I would be right back to community being like, ‘All right, who's had good experiences with who, who's had bad experiences with who?’ I trust community. I don't know more than, I don't know if I'm gonna [sic] call a doctor and be like, so who on your staff would be the most compassionate provider for me to see?

Impact of Provider Attitudes and Education

Understandably, one theme that came up frequently in participant narratives was that provider attitudes and education play a large role in participants’ experience of healthcare interactions. Likely due to the unfortunate frequency of negative experiences with providers, some participants appeared to have very low expectations, simply stating a desire for providers to act in a way that should be the bare minimum—such as treating TGNC patients with respect and not making assumptions about them or their experience. Participant 7 shared concerns related to this after experiences working in healthcare himself: “I've seen nurses and doctors make fun of and laugh at people and intentionally misgender. … Just because you're not doing it in front of the patient doesn't mean that it doesn't matter.” While many expressed understanding the difficulty of providers’ positions, they shared frustration when medical professionals don’t take the time to look at their charts for information and instead make assumptions that could be triggering for some individuals. For example, Participant 5 shared about providers assuming they were a cisgender male, saying “the amount of times I've gone in and have been questioned about my scrotum or penis. … I'm glad that how I feel about my body and stuff that it doesn't necessarily send me into a spiral.”

Participant 6 noted that compassion and openness can contribute to a positive experience even if a provider lacks knowledge or experience working with transmasculine patients:

> You don't have to be an expert to be compassionate. We can learn stuff together. Medical professionals do that with clients and patients all the time. And so I think that's a huge piece that the folks that made my life easier were the ones who just met me where I was at.

At the same time, participants were clear that the best care comes from providers who are not only compassionate and respectful, but also knowledgeable. Some spoke about the difficulty of finding educated providers and the experience of settling for providers who were willing to work with them. Participant 2 shared:

> it's kind of hard to get both someone who is trans friendly and has significant experience working with trans patients, but you can at least get someone who is going to try and

> work with you. Maybe they don't know, but they're willing to ask some of their colleagues or talk with you try and figure out, try and make it work somehow.

Participant 6, however, clearly stated that they did not want to settle for compassion only, saying, “I'm going to the doctor. I will, I want to receive compassion from my doctor. I also want my doctor to like be knowledgeable.”

The best providers seemed to be people who were educated, respectful, and took the time to listen to and advocate for their transmasculine patients. Two participants shared characteristics they’ve experience in the most effective providers. Participant 7 said, “the doctor that I have right now is more than wonderful. Super kind, super caring, super educated, and trauma informed, … knows all the things. I don't have to explain anything to him. It’s great.” Participant 5 shared, “And that's the thing too, like the best providers I've seen are the ones who don't just accept the system, how it is. Put the patients first, they do what they need to do for the patient.”

Need for Holistic, Individualized Care

Speaking to positive experiences with healthcare and advice for those providing care to transmasculine individuals, participants noted the importance of approaching care holistically, with an emphasis on a contextual understanding of the individual being treated. Participants noted a tendency for providers to focus on their gender identity sometimes to the exclusion of other important aspects of their experience.

Some participants spoke about the importance of providers recognizing the way intersectional identities may affect their treatment. They emphasized the idea that care must be approached holistically. Several participants shared the importance of providers recognizing and being educated on aspects of their identities. Participant 5, who self-identified as neurodivergent advised providers to,

> stay up to date on the studies, stay up to date on all the research that comes out because like there are still a lot of providers who do not understand the link between neurodivergency [sic] and transgender who do not understand like different ways those of trauma … how it all connects and how to take a holistic approach.

Although unable to clearly state the difference during the interview, Participant 3 who is of Middle Eastern heritage noted the felt difference when providers were culturally sensitive in their interactions, saying “I know it's important but I don't know how.”

Participants also shared positive experiences with providers who were trauma-informed and normalized asking for consent before proceeding. Many participants noted trauma histories of their own, so this aspect of care may be especially important for this population. It is also important for providers to understand gender dysphoria and ways in which interactions may be triggering for patients who experience it. For example, Participant 7 advised providers to use more clinical language when talking about body parts: “When you're talking about body parts, if they are parts that a person might be dysphoric about, don't say you like your vagina, your breasts. If you say the vagina, it helps.”

Similarly, multiple people noted that sometimes providers assume the transition process is an overwhelmingly positive experience for everyone and don’t always leave room for individuals to share their challenges and frustrations with the process. Participant 4 illustrated this by talking about complicated feelings regarding the effect of testosterone on sexual experiences: “I know at times the experiences of sex can be like, really the negative experiences for some people can be really upsetting and distressing even if you're getting the effects you really want.” Others shared about negative experiences such as providers congratulating them on "passing" or focusing on mental health improvements without acknowledging struggles. These experiences sometimes made it more difficult for individuals to seek care in the future.

Multiple people noted that healthcare providers, including mental healthcare providers, need to improve their approach to general care for TGNC individuals. They indicated a tendency for providers to assume problems are related to gender identity or transition rather than recognizing transmasculine folks as individuals with other aspects of their health and identity. Participant 6 expressed their frustration about the focus on testosterone, stating that "when we go to our GP about XYZ random ailment that so many times out of however many times the doctor is like, well, … we're just gonna chalk that up to testosterone." This tendency may be linked to a broader feeling of mistrust from providers that has further implications for accessibility. Participant 2 put it this way:

> Once the fact that we're trans comes into the picture, suddenly whatever problem we have could be assumed to be somehow related to our transition and it just gets zeroed in on, I think. … I think just generally some better understanding that just normalization like trans people are gonna [sic] need just normal health care too.

Participant 5 stated, "There's a tendency to want to attribute everything to being trans. And there's also in the same as cisgender women with medical providers and mental health providers of the lack of belief of what you say and it's just the bias that exists within the profession." Sometimes providers may react to this dynamic by swinging in the other direction (not acknowledging gender identity at all) leading TGNC folks to still feel missed in the process. The same participant stated the importance of finding a balance between these two extremes:

> I think just being able to find a way to acknowledge and work without getting stuck on it. To see that as one aspect of your identity, not your entire identity. And it's definitely

> relevant to my medical care. But it seems like sometimes it's sort of an either or it's either we're not paying attention to this at all and we're just sort of assuming that it's all going to be the same as your assigned gender at birth.

Member-Checking

Following the development of these themes, member checking was conducted by emailing the results and requesting feedback from interview participants. No concerns were noted about the representation of the community. Participant 2 indicated their agreement with the portrayal and shared their feelings about the convergence of the results, saying, “It was actually a bit of a relief to see some of the things that I know I would really want to get across … emerge as clearly identifiable themes echoed in more than one of our voices.”

Chapter 4

Discussion & Limitations

Discussion

Transgender health has been a hot-button topic in the U.S. in recent years. The controversy surrounding the appropriateness and importance of providing gender-affirming care may make it even more important for providers seeking to support this population to have accurate information about their experiences and needs. The original intention behind this study was to document individuals' experiences with testosterone and the resulting physical and psychological changes. However, participants' narratives seemed to highlight a different emphasis—education about the process and experiences with gender-affirming healthcare. Thus, following critical health psychology's emphasis following the participants' expertise on their own experience, the following areas seemed to be most prominent when considering ongoing healthcare needs: (a) gaps in information about HRT, (b) individual variability in HRT effects (c) complexity of nonbinary identity, (d) barriers in the transition process, (e) necessity and burden of self-advocacy, (f) importance of community support, (g) significance of sociopolitical context, (h) impact of provider attitudes and education, (i) and the need for holistic, individualized care.

The PR was pleasantly surprised to hear that many transmasculine individuals had positive interactions with healthcare providers as they sought HRT and most felt that they were adequately educated on the general transition process. However, as previous research has shown about TGNC individuals (Roller et al., 2015), this study demonstrated that transmasculine individuals continue to face a high burden of care. They must overcome many systemic and individual barriers that make accessing transition-related (and even general) care difficult. The barriers described in this study were in line with other research on barriers to care among the TGNC population (Roach, 2023; Teti et al., 2021). In order to get effective treatment, they are frequently required to do their own research which could mean anything from reading academic research articles to talking to others in the community about their experiences) and often have to educate their providers based on their own learning. Additionally, this study showed the necessity of self-advocacy, with participants noting that they often need to fight either individually or collectively to be heard and to have their needs met within healthcare systems. While it is inspiring to see how closeness and support within the transmasculine community, it is also a sign that transgender healthcare has room to grow in its ability to support its patients. These barriers are not new, and other researchers such as Lerner and Robles (2017) have proposed ways to increase provider education and decrease the burden on transgender patients interacting with healthcare systems. The problem with addressing these concerns may lie with implementation rather than information at this point in time.

One of these areas of growth may be related to a more general human tendency to generalize based on group membership, but this study shows that transmasculine individuals want to be seen as individuals and want to be seen more holistically. They spoke of a tendency for medical providers to push them towards the binary, even if they do not identify that way. There needs to be more recognition of nonbinary identities and more options for transition-related care (including HRT) that cater to those whose goals may be other than presenting as masculine as possible. This study also portrayed the frustration within transmasculine community about being reduced to a single identity—being trans. Other aspects of health and identity were often overlooked because of this emphasis. Viewing transmasculine patients more holistically—with consideration of other important parts of their identities, their experiences of socialization, health histories, and concerns related to their birth sex, to name a few—would likely both contribute to better health outcomes and make patients feel more seen.

The current study provides direction for (both physical and mental) healthcare providers working with transmasculine individuals. TGNC individuals frequently face harassment and discrimination, even in healthcare settings (Agénor et al., 2022; Drabish & Theeke, 2022; Shires & Jaffee, 2015), as highlighted by participants in this study, to be a trans-affirming practitioner the minimum qualification seems to be treating transmasculine patients respectfully and compassionately. This is demonstrated by actions such as using the correct pronouns/gender, collaborating with the patient in their treatment, and listening to the individual rather than making assumptions about their experience. And while transmasculine patients appreciate providers who are respectful and willing to learn, providers who seek to provide excellent care should also take the time to educate themselves so that their patients do not have to. This includes making sure one is up to date on at least the basics of professional standards of care (such as the ones published by World Professional Association for Transgender Health) and research on HRT. However, considering the frequency of gender dysphoria and the higher rates of trauma and PTSD among TGNC individuals (Brewerton et al., 2022; Marchi et al., 2023) one may also need to carefully consider ways to minimize dysphoria and act in a trauma-informed manner.

Given previous research connecting poorer health outcomes in the TGNC community and relating to minority stress (Flentje et al., 2020, Veale, 2023). These additional stressors may have large implications for the long-term health of transmasculine individuals, especially for those who hold multiple intersecting historically marginalized identities. This research also demonstrated the additional stress brought on by cultural factors, such as the current political dialogue about TGNC identity and health. For those seeking to provide care for this community, it is important to work towards removing systemic barriers and increasing provider awareness and education.

Limitations

Limitations for this study include the small and relatively homogenous sample of participants. Although there was some diversity in age, socioeconomic status, educational level, and geographic location, the majority of participants identified as White and most of them somewhere on genderqueer or nonbinary spectrum. Given the established effect of intersectional identities on experiences of discrimination (Farvid et al., 2021) further research should include a larger sample size and incorporate participants from more diverse racial backgrounds and those identifying more strictly within the gender binary which may help enrich future results.

Some recruitment efforts were met with suspicion due to the religious affiliation of the PR's graduate institution. This, and the PR's identity as a cisgender woman, likely contributed to fewer volunteers and may have led to a selection bias towards those who felt more safe engaging in such a study. The PR is also aware that not being a part of the transmasculine community being studied may have limited understanding and analysis of the results. While member-checking was utilized to mitigate this, future research either by transmasculine researchers or by non-transmasculine researchers with transmasculine-identified advisors working closely throughout the process may be needed to capture further nuances involved in these topics.

Conclusion

The results of this study indicate that, while transmasculine individuals seem to be receiving adequate information about the effects of HRT, they still face a host of challenges that make accessing gender-affirming care (and other types of care) challenging. Options for care have increased through time, but individual discrimination and systemic barriers still abound. The burden of advocating for change in this area seems to fall primarily on those within the TGNC community, which leads to additional stress, fatigue, and frustration for those who are already dealing with stressors related to stigma and discrimination.

Participants in this study seemed to temper their hopes and expectations for quality care. They often emphasized their willingness to “settle” for care that was not actively harmful. However, they expressed appreciation for providers who not only cared enough to be respectful, but also to be educated. Transmasculine patients should not have to settle for mediocre care. The results of this research should act as a call for those providing mental or physical healthcare to transmasculine patients to educate themselves and to advocate for their patients in systems that are often indifferent or even hostile to their needs. The concerns presented by participants are in line with other research on the experiences of TGNC individuals utilizing healthcare in the U.S. They have communicated their needs clearly—more education and research in areas like sexual health and nonbinary transition, educated and compassionate providers who treat patients holistically, and fewer systemic barriers to overcome in order to access care. Now, we must work to make these systematic changes within provider education/training and medical/mental health systems to meet these needs and make healthcare safer and more effective for TGNC individuals.

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Appendix A

Informed Consent

CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

Project Information

Project Title: Spilling the T: Transmasculine Experiences with Testosterone Therapy

Principal Investigators:
Katie Reinhart, MA; Amber Nelson, PsyD

Institutional Affiliation:
George Fox University
Graduate Department of Clinical Psychology
501 Villa Rd, Newberg, OR 97132

Research Description: We are requesting your participation in a research study conducted by Katie Reinhart and Dr. Amber Nelson. The purpose of this research is to gain better understanding of the experiences of transmasculine-identifying individuals' experiences with testosterone therapy.

If you decide to volunteer, you will be asked to complete a demographic questionnaire and to participate in one interview lasting approximately 60-90 minutes (but may take longer). You will be asked several questions about your experience with gender-affirming healthcare and hormone-replacement therapy. The interview will be audio recorded to ensure accuracy in the data analysis process. You will not be asked to state your name on the recording. You may also be asked to answer some follow-up questions after the completion of the study to elicit feedback on study results.

Risks and Benefits: This research may require you to recall some unpleasant memories which may cause emotional distress. Some of the questions may cause discomfort or embarrassment. Discussion about the experience of participating in the research as well as the opportunity to meet with a mental health professional after the interview will be used to address any emotional challenges. This is a chance for you to tell your story about your experiences with testosterone and your participation will serve to inform gender-affirming healthcare practices.

Confidentiality: Your responses to questions will be kept confidential. Personal data collected will not include your name or any identifying information and therefore cannot be linked to you. You will be assigned a random numerical code and all collected data will only be connected with this code. Interviews will be audio recorded for accuracy, and recordings will be stored in HIPAA-compliant, encrypted software. Your identity will not be revealed in any publication that may result from this study. In rare instances, a researcher's study must undergo an audit or program evaluation. This may result in the disclosure of your data as well as any other information collected by the researcher.

Participation and Withdrawal: Your participation in this study is completely voluntary, and you may refuse to participate or withdraw from the study without penalty at any time. You may withdraw by informing the researcher that you no longer wish to participate (no questions will be asked). You may skip any question during the interview but continue to participate in the rest of the study.

Contact Information: If you have any questions or concerns regarding this study or feel that you have been harmed in any way by your participation in this research, please contact Dr. Amber Nelson at anelson@georgefox.edu.

____ I have read this consent form and have been given a chance to ask questions. I agree to participate in the research study described above.

Name: ______________________________________ Date: __________________

Signature:____

Appendix B

Demographic Questionnaire

ID Number:
Age:
Race/Ethnicity:
Do you have any disabilities?
Gender Identity:
Gender Assigned at Birth:
Sexual Orientation:
Relationship Status:
Are you currently in school? ____ Yes ____ No
Highest level of education achieved:
Current employment status:
____Full-time ____ Part-time ____ Unemployed
If employed, general field of employment:
What social class do you consider yourself?
____ Poor ____ Working ____ Middle ____ Upper
Spiritual/Religious Identification:
How important is your religion to you on a scale of 1 – 5 (1= Not at all important. I have no religion, and 5= Extremely important. It is the center of my life)?
Are you from this area?
If you moved, did access to gender-affirming healthcare have anything to do with your choice to move?
How long have you been receiving gender-affirming medical services?
When did you begin HRT and how long have you been using testosterone?
Have you been on testosterone consistently during that time?
Other than HRT what other types of gender-affirming care have you utilized (e.g., surgeries, voice training, gender-affirming psychotherapy)?

Appendix C

Semi-Structured Interview Questions

1. When did you first recognize that your gender assigned at birth did not “fit” for you?
2. Did/do you experience gender dysphoria and what is that like for you?
3. Tell me about your process of accepting your identity.
4. Tell me about your coming out process.
5. What was the process of transitioning like for you from making the decision to beginning medical treatment?
6. Describe your mental health before you began medically transitioning.
7. How did your friends, family, partner, etc. respond to your transition?
8. What has your experience with the medical system been like during your transition process?
9. What kinds of barriers have you experienced in the process?
10. Tell me about changes you’ve experienced after beginning HRT with your:
    - A. Physical Experience
    - B. Sex Drive
    - C. Sexual Behaviors
    - D. Mood
    - E. Experience of Emotions
    - F. Mental Health
11. What other changes did you notice after beginning HRT?
12. Did HRT affect your experience of gender dysphoria? In what way?
13. How well did healthcare providers communicate expectations about this process to you?
14. What is/was missing in the literature and the information provided to you?
15. What do you think is important for health providers to know about this process?
16. Did/How did COVID impact your transition process?
17. How has the current political climate in the U.S. impacted you?

Appendix D

Member Checking Questions

1. How well do you feel these results represent your personal experience taking testosterone?
2. In your opinion, how well do you feel these results represent the experience of the broader transmasculine community?
3. Are there any themes you feel were missed?
4. Do you feel that any themes have been misunderstood or misrepresented?
5. Are there any themes you do not think should be included in the final results?