

THE FRED STUDY:
STORIES OF LIFE SATISFACTION AND WELLNESS FROM
POST-TRANSITION TRANSGENDER MEN

by

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ABSTRACT

The Fred Study is a Vancouver-based narrative study exploring life satisfaction, mental health and wellness as described by eight transgender men. Focus groups and follow-up individual interviews were conducted and guided in part using a strengths-based model commonly used in social work practice. Participants in this study discussed how peers and service providers alike perpetuate a dominant “negative transition story” which suggests all transgender men struggle with long-term substance abuse issues, depression, suicide, and life-long gender dysphoria, and will endure endless healthcare waitlists for hormones or surgical interventions ensuring they conform to normative gender standards and behave as heterosexual after transition. Despite these perceived challenges participants described having a positive transition experience while demonstrating resilience and self-efficacy in negotiating the healthcare system to access the care they desired. Coping strategies and impacts on mental health and substance abuse are discussed here, as well as implications for social work practice and ongoing research with this population. An assessment tool is described that mental health providers can use to assist trans clients uncover potential transgender-related stress or trauma.

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DEDICATION

For my dad, Fred Dewar, who encouraged me to follow my academic dreams and to whom I am eternally grateful.

1 INTRODUCTION

While recent years have seen increased interest in research on transgender communities, much of this has been deficits-based, focusing on the problems these individuals experience, particularly in regard to mental health and substance abuse. My intent with this research study is to provide an alternative view of transgender men in research, one that highlights their supports, resources and competencies rather than the ongoing pathologizing that underscores present literature. In doing so I hope to present a more complex, nuanced and participant-driven exploration of gender transitions and transgender communities.

Transgender People

Transgender people have existed throughout history and across numerous cultures, with many indigenous cultures recognizing some form of third gender individuals who are afforded great respect within tribal culture (Cole, Denny, Eyer & Samon, 2000). Susan Stryker (2008), among others, presents a fascinating and vibrant history of important transgender figures, researchers and clinicians, and describes the fight for transgender rights that continues to today (see also Lev, 2004). As both historical and contemporary transgender issues are made more challenging by the complexity of gender and its impact on individual and community experiences, discussion of these necessitates first reaching some agreement on language in order to talk and write about transgender people in a respectful way.

‘Transgender’ is considered an umbrella term that includes transsexuals, drag queens and kings, transvestites and genderqueers among a broad spectrum of individual identities and experiences that move among and between sex and gender categories (American Psychological Association, n.d.; Bockting, Robinson & Rosser, 1998). Sociologists Ekins and King (1999), in their grounded theory study of “cross-dressers and sex-changers” (p.580) incorporate three concepts of sex, gender and sexuality as they make operative a definition of ‘transgendering’ that “refers BOTH to the idea of moving across (transferring) from one pre-existing gender category to the other (either temporarily or permanently), AND to the idea of transcending or living ‘beyond gender’ altogether” (pp.581-582, original capitalization). Stephanie Brill (2009) of Gender Spectrum Education uses ‘transgender’ more specifically to

distinguish those who feel that their physical bodies do not represent their true gendered selves, whether or not they have chosen to adjust or change their gender presentation or undergo any medically-assisted gender reassignment. Brill, who works primarily with transgender and gender-variant children, consistently sets a clear boundary between discussions of gender and sexual identity, which may explain the desire to distance her work from the term ‘transsexual’ for having the word ‘sex’ within it.

The American Psychological Association (n.d.) describes ‘transsexuals’ as “transgender people who live or wish to live full time as members of the gender opposite to their birth sex” (p.3). Inherent in this definition are problematic assumptions of a gender binary and a complete transition. This Association states that transsexuals usually seek hormones and surgery to make their bodies as congruent as possible with their preferred sex, language that highlights and thus privileges a prescribed route of medical interventions over the individual and social experience of transition. The dominant medical literature tends to use ‘FTM’ (female-to-male) or ‘female transsexual’ in its categorization of these individuals (Forshee, 2008); the former provides information that may be useful in certain medical situations, while the latter is confusing to anyone but the psychiatric professionals who use it. When quoting others I use their terminology.

In this study I use the term ‘transgender’ differently. I recognize multiple genders, rather than just two, and suggest that these might be most easily understood as points among a continuum of gender. I use the term ‘transgender (or trans) man’ to refer to individuals who were identified as female at birth, socialized as girls and women, and are now living as guys or men within the transmasculine gender continuum; in this way I honour the ‘affirmed’ or expressed gender of these men.¹

The population of transsexuals and transgender people has also been the subject of much debate, in part due to the differences in language and definition. In

¹ Similarly, I use the term ‘transgender (or trans) woman’ to refer to individuals who were identified as male at birth, socialized as boys and men, and are now living on the trans-feminine spectrum of gender expression

light of the broad definitions of transgender, some have attempted to assess that the prevalence of transgenderism, as defined by the American Psychiatric Association (2000), as not a particularly common phenomenon and thereby dismissing these groups as small and insignificant (Lev, 2004). The American Psychiatric Association, in its current *Diagnostic and Statistical Manual of Mental Disorders* [DSM-IV-TR] (2000), lays out four criteria for individuals diagnosed with Gender Identity Disorder (GID) as a) “strong and persistent cross-gender identification”, b) “persistent discomfort with [natal] sex or sense of inappropriateness in the gender role of that sex”, c) “disturbance...not concurrent with physical intersex condition”, and d) “disturbance causing significant distress or impairment in social, occupational, or other important areas of functioning” (code 302.85). These criteria limit the range of people under the umbrella of ‘transgender’ to those meeting a particular diagnosis defined by a dominant medical institution.

Even with these criteria, the number of transsexuals has yet to be identified with any certainty. The *DSM-IV-TR* (2000) states that one in 100,000 females (FTM) and one in 30,000 males (male-to-female transsexuals) undergo gender reassignment. Seil (2004) reports that the prevalence is higher in countries where treatment is more readily accessible and acceptable. In the Netherlands, where transsexuals may experience easier access to surgeons and other care providers, transsexualism is seen in one in 11,900 MTF and one in 30,400 FTM people (Meyer et al., 2002), again based on those seeking gender reassignment. As Dickey (2009) points out, this suggests a ratio of one FTM for every three MTF individuals.

Conway (2002) reported significant errors in the prevalence numbers used in the *DSM-IV-TR*. She, and others (Human Rights Campaign, 2006), reported that the prevalence numbers used in the *DSM-IV-TR* date back to the 1960s when far fewer people were coming forward as transsexual and, further, represent only those who have sought out surgical interventions. For many years she has documented the number of specifically MTF gender reassignment surgeries (GRS) conducted by physicians in the United States and used these figures to estimate the prevalence of MTF GRS to be about one in 2,500. Further, she states that the prevalence of transgender individuals (non-operative) is one in about 500 adult males (Conway,

2002). Using Conway's calculations and the ratio of one FTM for every three MTF individuals, dickey (2009) suggests that one in every 8,350 adult females (FTM) have completed GRS and about one in 1,675 adult females (FTM) is transgender. There is no simple way to accurately determine the prevalence rates of this burgeoning community, (dickey, 2009; Lev, 2004).

Further, dickey (2009) explored the possibility of counting the number of FTM people as those who opt for 'top surgery,' a form of mastectomy with chest contouring. He states that top surgery is the only procedure most FTM people choose to have and yet, the number of plastic surgeons, gender clinics and general surgeons who offer the procedure make it difficult to calculate the number of people who get it done. Further complicating the calculation is that most insurance providers in the United States will not cover the cost of any GRS procedures. Wilson (2005) lists a total of six U.S. employers that allow for inclusion of GRS procedures as a part of their standard health care coverage. I found no estimates of the numbers of trans surgeries performed in Canada, but will discuss later the state of trans healthcare here.

Recent Issues in Transgender Health

In May of 2009, according to the Trans Secretariat of the International Lesbian, Gay, Bisexual, Trans and Intersex Association and as reported in *Le Figaro* newspaper ("La transsexualité ne sera plus classée maladie mentale"), officials in France removed transsexualism² from their version of the *International Classification of Diseases - 10* [ICD], the resource used by bureaucrats, policy makers, clinicians and insurance providers in Europe and other parts of the world to classify disease and other health issues, and code for insurance payment (World Health Organization, 1990). Without this designation, many wondered how transsexuals in France would continue to access healthcare (Drescher, 2009).

² The IDC-10 defines transsexualism under the rubric of 'gender identity disorder' as "[a] desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex."

Across the Atlantic Ocean, activists and clinicians in North America were debating the possibility of removing a similar designation from a forthcoming fifth edition of the *DSM* in 2012 (Drescher, 2009). The *DSM-IV-TR* (American Psychiatric Association, 2000) is presently the dominant resource used by mental-healthcare providers in North America to describe and treat mental illness. According to Peter Rothberg (2008), journalist and blogger for *The Nation*, of particular concern to trans-allied individuals was the especially contentious appointment of Kenneth Zucker of the Centre for Addictions and Mental Health in Toronto to co-chair the committee overseeing this review; Zucker is accused of being a proponent of ‘reparative therapy’ for transsexualism among children and youth who demonstrate gender-variant behaviours and/or assert their gender to be discordant with the sex they were determined to be at birth. Although there is a lack of evidence to support these accusations, the worry among activists is that Zucker’s leadership of the committee will result in the *DSM-V* recommending reparative therapy (Rothberg, 2008) and, further, categorizing transsexualism as a form of homosexuality (Drescher, 2009).

Trans woman and author Julia Serano (2009) cautioned about presenting an ‘us vs. them’ conflict over the *DSM-V* committee appointments and the resulting debate during her keynote address to the Philadelphia Trans-Health Conference:

In certain sexology circles, the negative reactions expressed by trans activists in response to these incidents have been caricatured as expressions of narcissistic rage³—a hysterical, irrational, mass overreaction to the supposedly logical, well-reasoned, empirically-based theories and diagnoses forwarded by psychologists. Reciprocally, in trans circles, psychologists are sometimes caricatured as heartless evil-doers who conspire behind the scenes in order to figure out how to further exploit and subjugate trans people via the *DSM*, *WPATH* [World Professional Association for Transgender Health] *Standards of Care*, and so on, in order to achieve academic success and/or monetary gain for themselves. (n.p.)

³ I thank Aaron Devor for identifying the term “expressions of narcissistic rage” as one attributed to Anne Lawrence, a noted MTF trans researcher and advocate.

These camps are far from definitive as there are many psychologists and other mental-health providers with great competence to work with trans people. Serano sees the difference as those willing to hear and accept that trans people have much to say and inform discussions of gender and their own care in contrast to those who dismiss the voices of trans people. Still, like Serano, others would also like to see transsexualism removed from the *DSM-V* and *IDC*, and instead address the health needs of trans people as more generalized physical health issues as practitioners in some jurisdictions are already doing (Douglass, 2009).

Broadly, the present literature about trans men includes legal papers, historical papers, sociological and anthropological works, and a growing body of medical and psychological literature written by trans professionals. There is also a medical literature focused on GID, the mental illness described previously which provides the rationale for treatment. Missing from most of the literature are the description and analysis of the spectrum of practical resources that trans communities and service providers can access. As trans activist Kyle Scanlon (2006) reminds us:

For too many trans folks ... being trans hasn't been an opportunity for subverting the patriarchy or playing with gender. Instead, being trans has meant fighting for survival, recognition, equality, housing, employment, safety and medical care. (p.88)

There is a need to understand better both the strengths and barriers trans people face in meeting basic needs and to use this knowledge to inform Best Practices for service providers working with them. This research project intends to fill this gap. As I will discuss in the next chapter, there are real concerns for the health of trans men. While the origins of these issues are disputed – whether forged in mental illness or a result of social stigmatization – the reality is that service providers need to address these concerns in practice today, while working to ensure equitable and appropriate access to healthcare in the future. As a social worker, I see this work falling clearly within the realms of my professional practice.

As social workers, we often work in mental-health and addictions-support capacities and may need to assist clients to unpack the role gender may or may not

play in the challenges they face. As generalist practitioners working in a hospital or child-protection or community-based agencies, we will very likely encounter individuals who are trans or who are gender variant in presentation. Our investment in social justice requires us to be not just aware of transgender issues, but to conduct an assessment of how our programs are gendered and how a transgender person would be supported or blocked in accessing services. We must be prepared to interpret the social needs of trans clients to other health professionals. Take for example an experience I had: At the end of an hour-long in-service for healthcare providers, a physician dismissed the necessity of the training stating the clinic did not have any transgender patients. Considering the efficacy of hormones and GRS for some individuals, I asked how clinic personnel would even know if a client was transgender. Some professionals and non-professionals alike seem to think they have the ability to visually identify every trans person, which is simply not the case. Levels of bias and misinformation are high among health care professionals and specialized training to work with a transgender population is far less frequent (Carroll & Gilroy, 2002). In fact, Sanchez (2002, cited in Maguen, 2005) states that the insensitivity of health care providers is the primary reason why transgender people do not access services. In my experience, new and current trans clients only begin emerging once a welcoming, trans-competent environment becomes clear.

Personal Connection to Transgender Health and Wellness

On a road trip along the West Coast of the United States from May to July 2007, I met a number of trans men, many of whom are now good friends. As a person with a longtime interest in gender issues and their impacts on peoples' lives and social interactions, I listened intently as these men shared their stories. One friend spoke of his teenaged years when, on a monthly basis and coinciding with his menstrual cycle,⁴ he would “get crazy, get wasted and fuck around.” On reflection he said he could ignore what was in his underwear rather effectively most of the time, but he was unable to cope with the physical manifestations of menstruation. Another

⁴ Here I use a masculine possessive pronoun in reference to menstruation to honour the affirmed gender of the individual who shared the story, thus creating a conflict of gendered language that often happens when writing about and working with trans people.

friend spoke about the challenges of dating as a queer trans man in a phallogentric gay community. His politics of disclosure were considered radical by many of our friends, more than a few of whom were concerned for his safety. Yet another recalled the absurd, unsympathetic and often degrading interactions he had endured with healthcare providers as he negotiated the obstacle course of medically-supported gender transition; sadly these stories were far too commonplace for the many trans people with whom I have spoken since. There were many other stories about the challenges trans men have faced and yet, despite these, they seemed generally well-adjusted and content with their lives.

These stories still echoing through my head, I surveyed the extant literature for research that explored mental health and wellness among trans men. I was operating with the Canadian Mental Health Association's (n.d.) definition of 'mental health' as a measure of life enjoyment, resilience in the face of stress or challenges, balance among different areas of life, self-actualization of our abilities and strengths to reach our full potential, and the flexibility to balance emotions and expectations. While the literature was small, I did find a number of psychiatric articles that presented trans men only as sufferers of mental illness (Cole, O'Boyle, Emory and Meyer, 1997; Lobato, Koff, Manenti, Salvador, da Graça, Petry, et al., 2006), an image that was a stark contrast to that of my friends. Many of the reports linked this so-called 'illness' to depression, substance abuse and suicide; here, there was even less resonance to the people I had met. As I looked deeper, I discovered an even smaller collection of articles, books and clinical guidelines, written by trans people and non-transgender allies, that began to resemble the narratives I had heard on my journey (Devor, 1997; Lev, 2004).

Having identified a clear gap in the literature and resources, and concurrently receiving support from friends and professionals working within trans communities, I decided to focus my graduate research on learning more from, and then sharing, the stories of trans men who are contented with their lives despite, and often in appreciation of, the challenges they have experienced in their lives. My intent remains that, by bringing a critical social work lens to this research, I can provide for my professional colleagues and our allies some recommendations for effective and

culturally appropriate social work practice with trans communities. More importantly, I hope that my findings will improve the future experiences of trans men who decide to employ our support as they consider, initiate and progress through an important stage in their lives: transition.

My own social locations. As a non-trans queer man I was at first skeptical of my capacity as a community outsider to successfully conduct this study. Would my work scream of biocentrism? Would my class, education and white-male privilege negatively impact the project? Perhaps another trans man should do this work. Yet many discussions with community members and service providers revealed the need for informed, non-trans allies to support the movement toward social justice for trans people. As an anti-oppressive researcher, I take seriously the advice of University of Victoria social work researchers Karen Potts and Leslie Brown (2005) to engage in ongoing reflection, critique and challenge my research process and the resulting knowledge production in order to transform research, social work, and society (p.260). Moreover, my goal with this project is to “construct emancipatory, liberatory knowledge that can be acted on, by, and in the interest of the marginalized and oppressed” (p.262) who are, in the case of this project, trans communities.

In order to be transparent about how I brought particular lenses, experiences, and perspectives to this work, I recognize myself as narrator and primary author of this work. I am a queer man, trans ally and social worker; these social locations both inform and bias my analysis and re-presentation of the stories of trans men within this report. Further, I recognize how these locations can create a chasm between the study participants and myself as researcher; Fine (1994) refers to this dynamic as the Self-Other dichotomy. Commenting on Fine’s work, Ester Madriz (1998) explains: “Whereas the Self often represents what is middle class, White, and often male, the Other is often identified with the colonized – women and men of color, poor people, gays and lesbians, and individuals with disabilities” (p.115). In order to counter this dichotomy Madriz recommends researchers create environments in which they stand with, rather than in opposition to, oppressed groups. In my approach to this work with trans men, and in each interaction, I made every effort to reduce the impacts of these relational differences.

I bring attention to some of the mistakes I have made along the way not only in the interest of transparency, but also to share the learning I take from these errors that future researchers may find helpful to avoid similar pitfalls. I have made efforts to vet the stories in this study through many conversations with trans men at conferences and in my own social network. I also shared these with the members of the project Advisory Group, local trans men who provided valuable insights during development, execution and analysis of this research project; I discuss their role in the research project more later. I alone take full responsibility for any inaccuracies and errors contained herein.

As a social worker and community-involved individual, my anecdotal experience has been that the majority of people find trans issues unfamiliar, curious, and sometimes highly uncomfortable. There is a dearth of information available in general society about trans communities and what does exist, is often inaccurate. My own investment in trans issues developed as I met more and more trans men within my own social networks and in my practice. I took it upon myself to learn more about the trans experience so that I could be a more effective friend, social worker, and ally. Ally-ship honours the integrity of trans individuals and their communities and keeps in mind the words of Kyle Scanlon (2006) that a “trans ally is someone willing to stand up and fight for the basic human rights and dignity of all trans people” (p.88).

I must keep in mind the history clients may have had at the hands of other less-competent providers (Raj, 2002) and the resulting distrust. I hold some of the responsibility for that distrust; as a non-trans person, a citizen, and a healthcare provider, I recognize that I have contributed to the ongoing oppression of trans and gender-variant people. I have in past used language that perpetuates the discrete categorization of behaviour, appearance and gender performance, and in so doing marginalized and in some instances perpetuated the gender binary. These are the burdens that all providers share, regardless of their gender identity.

With this research project I present pragmatic recommendations for social work practice that can both facilitate transition for trans people, and encourage competent generalist practice with all gender-variant clients. To that end, my

framework for inquiry draws on a strengths-based model (Saleebey, 1996; Graybeal, 2004) more typically used in social work practice to inform my social work research. From this perspective I take issue with a medical literature that identifies deficiencies within trans communities, while rarely highlighting strengths.

Assumptions

There are a number of assumptions that are inherent in this research project. I assume that a critique of the medical institution as a whole and how medicine is practiced and performed is necessary. Within this critique an evaluation of the way transsexuals and trans people fall under the mental illness rubric as defined by the American Psychiatric Association's diagnostic criteria is necessary. I come to this work with a belief that trans men have something of value to share and I bring an openness to support people who are exploring, shifting or changing their gender. My belief as a researcher is that trans men are not mentally ill solely on the basis of being trans, despite the appearance of such as a result of gender identity disorder appearing within the DSM-TR-IV; trans people are not mentally ill just because trans is categorized as a mental illness. I do not deny that trans people are at risk for all the mental illnesses any non-trans person could have, and may be susceptible to mental illnesses related to the stress they experience due to discrimination and marginalization. Despite implications of pathology subsumed within this psychiatric diagnosis, I assume that it is possible for a trans person to lead a happy life and, where a trans man reports having a happy life, I accept that self-report at face value. Finally, by hearing stories of satisfaction I recognize the possibility of affecting change and perhaps enhancing the lives of trans men.

Context

The appearance of openly trans people in the social context has been a relatively recent event. A number of authors have offered in-depth studies of trans people in society that I will not attempt to recreate here (see Cole, Denny, Eyer and Samon, 2000; Devor, 1997; Lev, 2004; Stryker, 2008). Trans people have often been socially situated within lesbian and gay communities and assumed to be a homogeneous group despite unique differences between gender and sexual identities; sexuality and gender are often conflated thus creating confusion for many

in everyday conversation (Forshee, 2008). The experiences of trans people as discussed in the professional literature is often located within health institutions and limited to those where surgical procedures take place. This is a site of medical intervention for trans people and, therefore, part of the social experience of transition. The lack of standardization in the provision of services can add to the tenuousness of the experience. Fortunately, this is also the place where social workers can operate as allies. Unfortunately, the relationship between trans people and their healthcare professionals remains a contentious one as a result of providers who have operated with questionable ethics and used their 'gatekeeper' status to enforce gender-normative behaviours and participation in demeaning research protocols (Raj, 2002).

Even within the problematic medical milieu where diagnostic options and treatments are delineated, many transgender people struggle to access the care that is prescribed therein. A survey of the trans healthcare landscape is helpful here. In Vancouver, a gender clinic at Vancouver General Hospital provided assessment and treatment of individuals diagnosed with GID until 2002. According to the Vancouver Coastal Health (VCH) website (2009), this clinic was part of the Centre for Sexual Medicine and offered its patients "endocrinological, urological/gynecological, psychiatric, psychological, and social services, and was the sole gatekeeper for public health coverage for transition-related surgeries." The program ended when provincial budget cuts forced the Department of Psychiatry at the hospital to reduce the program size. As a result, clinic staff felt they could no longer provide service to transgender people. After the closure of the clinic, a community consultation led to the development of what is now the Transgender Health Program (THP) also offered through VCH. The THP provides referrals, resources and training on a range of topics for both trans-community members and service providers.

Elsewhere in British Columbia there are specialists who offer some trans-specific services, and the THP often provides training to ensure the competence and cultural capacities of these professionals. Across Canada, the Sherbourne Health Centre in Toronto has a reputation within trans communities for offering trans-sensitive service, while the Centre for Addictions and Mental Health

(CAMH) in the same city has a more conflicted history with trans communities. In Montreal, the GRS Surgical Clinic has a long history of providing surgical care for transgender people.

Coverage of gender reassignment treatment by medical insurance plans varies among provinces and territories. Variations include: which surgeries are covered; the amount of coverage, which often does not cover the full cost of procedures; and whether surgical assessments and the procedure are provided in- or out-of-province. British Columbia has its own surgical assessors, and provides some coverage of some GRS surgeries. For trans men, chest contouring surgery is not covered, however the Medical Services Plan will contribute \$1,500 toward mastectomy performed at private facilities, leaving a remaining \$6,000 to \$7,000 to be paid by the individual; phalloplasty is not covered. For trans women, the costs for penectomy, orchiectomy and vaginoplasty are covered at the GRS Surgical Clinic in Montreal; individuals must cover their own travel and accommodations costs. The province has a trained surgeon who could provide all necessary GRS-related surgeries, however the provincial government will not provide use of public surgical facilities (Knudson and Corneil, 2009).

According to Knudsen and Corneil (2009), the terrain varies across the country: Alberta formerly covered all surgeries for up to 16 individuals a year, but cut all funding to GRS in April 2009 resulting in a Human Rights Commission complaint (CBC, 2009). In Saskatchewan and Manitoba, trans people must travel to CAMH in Toronto for surgical assessment; some surgeries are provided in province while the rest are performed at GRS in Montreal where only direct surgical costs (about 25% of total cost) are covered. As a result of a Human Rights Commission ruling, Ontario began providing full coverage for transgender surgeries as of June 2008. CAMH currently provides assessments although other community groups are attempting to expand access to assessments. In Quebec, hysterectomy is provided in-province and other surgeries were historically referred to the Czech Republic or Thailand until earlier this year when the province approved referral to GRS Surgical Clinic in Montreal. New Brunswick, Nova Scotia and Prince Edward Island have trained assessors as of 2008 but the provinces will not provide coverage of surgeries; a

lobby group is preparing proposals to change this. While in Newfoundland and Labrador surgeries are apparently covered after assessment at CAMH, no one has yet received any of the surgeries. Information regarding how GRS is covered in Nunavut, the Yukon and Northwest Territories was not available.

There are further structural challenges related to transition in terms of jurisdictions that require surgery in order to change the gender on a birth certificate. For example, in British Columbia, section 27 of the *Vital Statistics Act* (1996) requires evidence of “trans-sexual surgery” in the form of a letter from the surgeon who performed it, and a physician within the province who has examined the individual affirms that “the trans-sexual surgery is complete by accepted medical standards.” A trans man might not want to have surgery and also not want to live with a driver’s license that categorizes him as female. As a result he might feel pressured towards surgery and forced to decide what is more important: having the gender category on his driver’s license represent him accurately or accept the risks of unwanted surgery.

Delimitations

This study focuses on a particular group of trans men and may not be generalizable in a statistical sense to other trans men. That stated, these findings may still be useful and contribute to understanding issues in serving other trans men. I did not explore the experiences of trans women; while some of the issues may be similar, neither the methodology nor the analysis of the data considered the trans-feminine spectrum. Generalization from the findings of this study to the trans-feminine spectrum would, therefore, be problematic.

This is a study about gender and not about sexuality, two concepts that have historically been conflated (Forshee, 2008), perhaps due to the so-called lesbian, gay, bisexual and transgender (LGBT) community and the inferred affinity between these groups. Stryker (2008) recounts in her book *Transgender History* numerous intersections, often under the banner of united protest and celebration. There was the riot in San Francisco at Compton’s Café in August of 1966 when the “usual late-night crowd of drag queens, hustlers, slummers, cruisers, runaway teens, and down-and-out [Tenderloin] neighborhood regulars” responded to ongoing aggressive

police behaviour with a barrage of dish and tableware and fighting on the street (pp.64-65). Almost three years later in New York City, trans people and their gay and lesbian compatriots fought a similar battle against harassment in front of the Stonewall Inn. More recently there are LGBT pride parades in most Western cities nowadays, and trans and queer people are working together within organizations such as Lambda Legal and the Gay and Lesbian Task Force to further rights for all sexual- and gender-minority people. Relations between these groups have endured a long history of tumult and celebration, and yet we cannot allow this relationship to confuse the unique differences between them. This study is focused very specifically on experiences of gender and not on the stories that participants share about their sexual identity. This is not to deny kinship between trans people and lesbian and gay people that has emerged from a long mutual history of shared oppression, but my approach honours many people's lived experience that gender identity and sexual orientation are separate issues.

Conclusion

This project intends to bring a critical lens to the stories trans men share about their transition experiences and post-transition lives, and what makes them content. In doing so, I intend to highlight individual and social experiences of transition over the medicalized ones. In the interest of being transparent about the critical lens I bring this work, in the next chapter I explore the theoretical literature first and the medical afterward. In Chapter 3, I describe the methodological process I used to study the stories shared by eight generally-satisfied trans men. In Chapter 4, I share the findings and, finally, in Chapter 5, provide a discussion of the findings in relation to current research and theory, their implications for social work practice, and future directions for research.

2 CONCEPTUAL CONTEXT

This chapter is divided into three parts. In *Theoretical Underpinnings*, I begin with an exploration of the history of ‘transgender’ in feminist theory and a discussion of trans-feminist theory, the lens through which I undertook this study. I then present models for the assessment of life satisfaction and well-being, and relate these to recent literature on quality of life of trans people. In *Theoretical Identity Frameworks*, I look at identity from two perspectives: the first involves two complementary models of trans-identity development, while the second explores and critiques how transgender identity is created in the extant health and mental health literature. In *Implications for Practice*, I discuss the role of the social worker or mental health professional in transgender care, and conclude with an explanation of strengths-based practice and how it informed the design of this study.

Theoretical Underpinnings

The utility of feminism in transmasculine studies. Much like Canadian artists who attempt to represent our geographic landscape will always need to respond to the canonical Group of Seven artists, the feminist perspectives on the ‘transgender issue’ will forever be obliged to engage with the vehement protests of radical feminist Janice Raymond. In ‘The Politics of Transgender’ (1994), an update to her influential book *The Transsexual Empire* (1979), Raymond heartily singles out trans women who are not “real women” but rather “patriarchal...stereotypes of femininity” (p.628). According to Raymond, trans women are drag queens and appropriators of women’s gender performance; as an essentialist, Raymond refuses to acknowledge anyone who is not a natal woman. In light of her categorical organization of gender, it surprises me that Raymond ignores trans men in her analysis, who are merely a group of natal women based on her criteria.

Interestingly Raymond privileges those trans people who engage with the medical establishment and undergo sex reassignment surgery; these are the “true transgenderists” (p.629), compared to those who just use hormones. She not only reveals her ignorance about the need for ongoing, post-surgical, endocrine therapy, but also exposes a decidedly curious support of the patriarchal medical institution that is complicit in the pathologizing of trans and other gender-variant people.

Finally, when Raymond decrees that “transgenderism reduces gender resistance to wardrobes, hormones, surgery and posturing – anything but real sexual equality” (p.632), she denies trans people their subjective experience of internal/external dissonance and their goal of finding a place of honour for themselves in a society where hegemonic ideals about sex and gender dominate each and every one of us.

What are Raymond and her radical feminist compatriots so afraid of? Surya Monro and Lorna Warren (2004) contend that the artillery is out because the battle is foundational:

Transgender poses a serious theoretical challenge to feminism. Feminisms, particularly radical feminism, are based on the notion of an unequal gender-binariated system. Transgender scrambles gender binaries and opens up the space beyond or between simple male-female categorization. It also highlights the flaws in...the simplistic equation of masculinity with oppression. (pp.354-355)

Having reviewed this literature and conducted this study, I challenge radical and other essentialist feminists’ anti-trans criticisms: What are the categories that make a woman? Some suggest biology and sociology, nature or nurture, or hormones and female reproductive organs. But are women limited to XX chromosomes? Must women be raised and socially gendered as girls? How do we value different naturally-occurring versus pharmaceutically-adjusted hormone levels between younger and older women, and those with endocrine issues? How does cancer-initiated hysterectomy differ from removal of the uterus during gender reassignment surgery when both procedures are identical? These questions point to contradictions embedded in essentialist assumptions regarding gender that underlie questions about the authenticity of trans men’s experiences.

Krista Scott-Dixon, a Canadian Women’s Studies scholar, explores in her anthology *Trans/Forming Feminisms* (2006) the relationship between feminism and trans experience, unpacks social constructions within the dominant gender binary, and engages in a critical dialogue about the implications of trans-feminisms. Scott-Dixon highlights the importance of framing ‘trans’ as “a social and political, rather than a medical and psycho-therapeutic, category” (p. 18). In doing so, she brings to

the forefront the subjective experience over that of the medical one. The author contends it is within the latter category that trans people face the greatest amount of stigma due to being non-normatively gendered as opposed to those who experience the gender privilege of “normatively and unambiguously placed within a mainstream gender system” (p. 20). Later, in the Discussion chapter, I will explore how gender privilege may benefit some trans men, particularly those who are ‘read’ more easily as men than others.

Scanlon (2006) furthers this particular discussion with his elaboration on what he calls biocentrism:

The privilege of being a person whose assigned sex at birth matches their gender identity throughout their lives...the assumption that people who ‘match’ in this way are more ‘real’ and/or more ‘normal’ than those whose assigned sex at birth is incongruent with their gender identity. (p.88)

Non-trans people run the risk of seeing trans as non-normative and thereby subjugating the behaviours of trans people as abnormal. Thus the review of any present literature requires this critical lens in order to identify such bias and within which we must heed. Cole, Denny, Eyler and Samons’ (2000) caution about a thoughtful use of language because some terms like ‘disorder’ may predispose a reader toward seeing trans people as deficient or mentally ill. “When resorting to the traditional medical-psychology model, it is difficult to discuss transgendered persons or their issues without using terms that imply or overtly state pathology” (p.163).

I have concerns specifically related to the utility of feminism in the exploration of trans men’s identity. I am apprehensive that the inclusion of feminism in a discussion of transmasculine people might perpetuate for some the idea that trans men are essentially women. Regardless of how they may self-identify, they are perceived by some as having experienced the world as girls and women, and thus some part of them will always remain female. But is there an essential subjective experience of being a girl who grows up to be a woman? Is this experience different for those for whom a dissonance between inner/outer gender exists? These are some of the questions I am trying to understand as I attempt to frame my research and social work practice.

Feminism, particularly social-constructionist feminism, provides an analysis of power and oppression within a patriarchal society. Cole, Denny, Eyler and Samons (2000) describe how this work helps us understand how the organization of gender into a binary contributed to a 'transgender model' that evolved in the early 1990s when notions of multiple, perhaps infinite, sexes re-emerged and the anatomic phenotype 'sex' and psychological phenomenon 'gender' began to decouple. Further, they suggest that as gender roles dissolved, more people began to see themselves as both man and women, neither man nor woman, or as an entirely different gender: "Under this model, the in-between state somewhere between manhood and womanhood...[is] a goal for which to strive, or at least a comfortable place at which to rest" (p.160-161).

Still, Lorber (2005) contends that the transition experience, or what she refers to as the "phenomenon of transgendering" is "meaningless without established gender categories" (p.26). Further, she suggests that it is because of these categories that trans people feel the need to engage in this process and be 'read' as the desired gender for the purpose of operating in daily life rather than subverting the gendered social order. Here I believe she addresses the pragmatism of transition previously described by Scanlon (2006). As Irish academic Myra Hird (2000) suggests: "Let me be clear that my objective is not to highlight the difficulties of 'including' intersexuals and transsexuals as women, but rather to question how *anyone* claims this membership based on the current 'sex/gender' binary." (p.350, original emphasis).

This critical lens allows us to understand more fully the complexities of the trans experience within the broader context of trans peoples' lives. As Scott-Dixon explains (2006):

Focusing on trans people alone as subjects of study does not capture the ways in which even normatively gendered people might support or subvert gender roles and regimes. The privilege of being 'perfectly' gendered is also racialized, classed and shaped by other elements of social location, such as age, ability and sexuality, all of which affect how we perceive our gender, and how others perceive us. (p.18)

Gender identity, like sexual orientation or race, is not the only point of oppression or privilege an individual is going to experience. Also problematic is the assumption that the experiences of one oppression are the same as another.

For example, the grouping of trans and queer people into a so-called LGBT community is necessarily problematic in that it suggests that the experiences of LGB people in terms of *sexual* identity are identical to those of trans people and their *gender* identity. As Forshee (2008) explains, “the conflation of sexual orientation and gender identity confuses research on each population’s unique needs and perspectives.” (p.232) While some trans people may also identify as queer, these are different journeys altogether, albeit with some similar social ramifications. Thus the reason queer and trans people have historically come together may not be because they share a similar inner journey, but rather that in ‘coming out’ we face similar oppression from a society, often at the same time, as Stryker (2008) described.

Life satisfaction, Subjective Well-Being and quality of life. Shin and Johnson (1978) define quality of life as a global assessment of a person’s well-being according to individually chosen criteria (p.478). Examining trans men’s experiences through the lens of life satisfaction is a way to remove the limitations imposed by the lenses of mental illness diagnoses. Originally I considered exploring experiences of ‘happiness’; unfortunately the term, described by Chekola (1974) as the harmonious interplay of a person’s goals and desires, is so commonly and broadly used today that the definitions are too many and too vague. Moreover, I was concerned that the term ‘happiness’ inferred a necessarily positive subjective experience that I wanted to avoid in this project

In the literature, life satisfaction falls under the broader psychological construct of subjective well-being. According to Diener (1984), subjective well-being is composed of three elements: first, it is based solely on the inner experience of the individual rather than fact; second, subjective well-being is assessed by considering the presence of positive factors as well as a lack of negative factors; and finally, this assessment is global in nature, meaning that individuals generalize their experience despite potentially feeling that some domains of their lives are sub-optimal. He

further states that subjective well-being “stresses pleasant emotional experiences” and their relationship to unpleasant ones (p.547). Diener states: “This may mean either that the person is experiencing mostly pleasant emotions during this period of life or that the person is predisposed to such emotions, whether or not he or she is currently experiencing them.” (p.543) According to Ryff (1989), the realms of life people tend to focus on when assessing their subjective well-being include self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth.

Similar categories are measured in research focused on quality of life (QOL), an area of inquiry that, according to Newfield, Hart, Dibble and Kohler (2006), uses tools to assess “the level of functioning and perceived well-being in a patient population” (p.1448). Emerging results from Jamison Green’s (2009) online survey of trans men’s sexual satisfaction found that 87.9% of almost 1,300 respondents reported average or better than average QOL using a single item query; analyses of these data collected in April to June 2009 are only just beginning. Newfield and colleagues (2006), in their online study of 376 participants, found trans men scored lower than the American national average in the areas of mental health (Vitality, Role Emotional, Mental Health, and Mental Health Summary Score) and for social functioning (reflecting physical and/or emotional impact on social activities) which suggests decreased mental-health related QOL (p.1450). These researchers used a well-replicated QOL questionnaire with a group of participants who were mostly white (89%) with a mean age of 32.6. Last year, Colt Meier and Kara Fitzgerald (2009) found similar results in their online survey of 369 FTM using the same QOL tool as Newfield and colleagues; participants were mostly white (76.7%), with an average age of 28.

Theoretical Frameworks

Models of transgender identity development. Little empirical literature exists about transgender identity development (Maguen, Shipherd & Harris, 2005), however two developmental models and a categorical framework have been proposed to understanding experiences of trans people. In her book *Transgender Emergence: Therapeutic Guidelines for Working With Gender-Variant People and*

Their Families, social worker Arlene Lev (2004) describes the six stages of her model of “transgender emergence,” the “developmental process whereby gender-variant people examine themselves and their identity, within a context of compassion and empowerment, and progress to an authentic and functional sex- and gender-identity congruence” (p. xx). Informed by an early version of Aaron Devor’s (1997) 14-stage model of trans identity development discussed later, Lev’s approach uses a postmodern lens to deconstruct gender, sexual orientation, and the diagnostic categories used to treat transgender people. As Harding and Feldman (2006) stated in their review of the book, the title alone is a “reminder that the experience of sexuality and gender does not occur within a vacuum but within the context of family and community systems and their not always supportive reactions” (p.628).

Developed through many years of counseling her trans clients, Lev’s (2004) six stages begin with *Awareness*, wherein individuals recognize a sense of difference as the authentic self emerges. They recognize that they cannot deny a history of cross-gender thoughts and behaviours. The result for many is a state of emergency caused by severe psychological pain. In the second stage, *Seeking Information and Reaching Out*, people seek out narratives and sometimes theoretical and political materials to inform their internal process, resources that are now much more accessible via the Internet. Individuals reach out and often disclose for the first time to a therapist or group, develop one-on-one relationships, and begin to re-examine personal histories. In the third stage, *Disclosure to Significant Others*, many will have the desire to reveal themselves to partners, family and friends and yet feel conflicted and frightened at the impact this will have on those they love; avoidance is common, as is fear of discovery of cross-gendered behaviours by intimates. Upon reaching the fourth stage, *Exploring Identity and Transition*, they are considering labels like ‘transgender’ and ‘transsexual,’ exploring gender role performance, the importance of passing, and options like testosterone replacement therapy (TRT) and GRS. Lev cautions this is one of the most difficult stages with great potential for mental health and substance-use issues for those without strong coping skills. During the fifth stage, *Exploration: Transition Issues and Possible Body Modifications*, transgender people are making decisions about TRT and GRS, often

beginning treatment, and beginning to living more regularly as their affirmed gender. While for trans men, the effects of TRT are generally sufficient in order that they can be 'read' or perceived as male, some trans women come to terms with the possibility of always being seen as trans. Generally, with the sixth stage, *Integration and Pride*, trans people have completed desired surgeries and made decisions about living 'out' as trans or more 'stealth' and invisible in their community. They go through a process of synthesis of self and integration of the gender they were socialized as, and that which they currently live.

At first glance these stages do resemble a 'coming out' process and, indeed, Lev borrows from models of gay and lesbian identity formation. For Lev, 'coming out' is about self-disclosure of personal and often stigmatizing information (p.229). These stages do seem to have a teleological end-goal of reaching the sixth stage, though Lev does caution that people may move back and forth and revisit stages. She also states that factors like race and access to financial resources impact the process (p.234).

Aaron Devor (2004), a sociologist at the University of Victoria, proposes a model of 14 stages of transgender identity development based on many years of extensive research, interviews, and both personal and professional interactions with trans people. According to Devor two concepts are foundational to all identity formation: witnessing and mirroring. Witnessing refers to the desire we have to be seen by others as we see ourselves. Mirroring involves seeing oneself in the eyes of someone who is similar, a person with an insider perspective on the group with which we identify (Devor, 2004). The 14 progressive stages are: 1) abiding anxiety; 2) identity confusion about originally assigned gender and sex; 3) identity comparisons about originally assigned gender and sex; 4) discovery of transsexualism and transgenderism; 5) identity confusion about transsexualism and transgenderism; 6) identity comparisons about transsexualism and transgenderism; 7) tolerance of transsexual and transgender identity; 8) delay before acceptance of transsexual and transgender identity; 9) acceptance of transsexual and transgender identity; 10) delay before transition; 11) transition; 12) acceptance of post-transition gender and sex identities; 13) integration; and 14) pride.

Although transition is an individualized process, according to Devor (2004) the narratives of identity formation emanating from the above 14 stages have common elements. Many transsexuals experience discomfort at early stages of identity formation in reaction to the dichotomous gender roles imposed in Western society. Some grow increasingly agitated in response to family and friends' discouragement of non-normative gender behaviour and then seek out groups that come closer to matching their internal sense of gender, often among lesbian women and gay men. Some have an epiphany on discovering transsexualism and meeting people within transgender communities. Online resources may inform a tentative self-assessment of transgender identity and a reflection on the possible impacts on self and others. After meeting a trans person for the first time some will quickly self-identify as transsexual, while others take more time; encouragement and support are vital at this stage and throughout the process, as are having people with whom, and places where, they can be open about their experiences. Lack of support, resources and concerns about acceptance may fuel indecision.

Devor (2004) goes on to state that individuals experience a wide range of emotions from elation and relief to sadness at losing part of their life-long identity. Transition is complete for some when they are witnessed within their social networks and communities as the gender to which they wish to transition, while others may choose TRT and GRS. Once transitioned, living as the affirmed gender may feel surreal for a time. Most transsexual people eventually find themselves "seamlessly integrated into society at large" (Devor, 2004, p. 17) and with decreased need for being witnessed. Comfortable with the lived gender experience, they may develop personal pride and the desire to speak more publicly about their lives and communities.

While Devor cautions that this model does not represent a common experience for all transsexuals, for this discussion it is important to clarify that issues of race, class, ability/disability, biological receptivity to testosterone, and health status are all mitigating factors that can have substantial impacts on individuals' experiences of transition. Further, Elijah Adiv Edelman (2009), seemingly viewing the model as a purely progressive process, believes that Devor's final two stages

are “antithetical in nature” in that they make “it impossible to both live as stealth and be an advocate for trans issues; stealth is rendered as a particular stage in developmental sequence” (p.168) Devor (2004) states that people can go through the stages in different orders. Maguen, Shipherd and Harris (2005) report anecdotal evidence of the model fitting well in the therapeutic work they do with transsexual American veterans they see in Boston, particularly as evidence of the motivation for some enlisting as an act of performing a gender-stereotyped behaviour. These authors concur with Devor by offering the caveat that “the model is a heuristic for each of the stages a given individual passes through [and that] there are many individual variations in the quest for a cohesive transgender identity” (pp.480-481).

Griffin Hansbury (2005), a trans man and social worker in New York City, described from his therapeutic and personal experience three broad categories of transmasculine identity along a spectrum that he believes inform the therapeutic needs of trans men. ‘Woodworkers’ are the “run-of-the-mill, Joe-six-pack, female-to-male transsexuals” who generally identify simply as men and often live under the radar (p.246). ‘Transmen’ occupy the center of Hansbury’s transmasculine spectrum, and are individuals who acknowledge their past history as female-bodied persons and the journey of ongoing transition. ‘Genderqueers’ tend to deny and defy classification of any particular gender even if their appearance suggests masculine identity; these individuals tend to experience the greatest amount of stigma. With these categories, and the subgroups along the spectrum — transfag, boy-chick, new man, ungendered — Hansbury brings to the forefront issues of identity in terms of how individuals relate to one another along a spectrum of identities. Gayle Salamon (2005) writes:

Hansbury convincingly argues that transmasculinity can best be understood not as fidelity to any single ideal of gendered embodiment, or conformity to a singular fantasy of the uniformly male body, but rather as a range of masculine bodily expressions and feelings. His emendation of the totalizing concept of community with the language of the spectrum allows masculinity to be understood as a *way* of being (more or less masculine) rather than a *kind* of being (transmen versus nontransmen), less a fixed ontology of

transgenderism and more a performative account of transgenderism.
(p.266, original emphasis)

Hansbury is interested in the recognition of a transmasculine 'community' – language he both uses and problematizes – and identity as it relates to individuals' narrative rather than their behaviours.

These models provide a rough framework that helps those less familiar with trans identity to situate both research and narratives about trans experience within the context of trans lives. The risk of models such as these is that researchers and practitioners may interpret them as a teleological narrative and then assume that all trans people will have the same experience. This risk is still, in my opinion, less than that posed by traditional frameworks for trans healthcare that privilege the medical transition experience and ignore the fundamental psychosocial impacts of transphobia.

Medical and psychiatric etiologies as pseudo-identity models. While trans people and allies were creating new models to understand trans identities, the medical institution had already attempted to describe it from a place of pathology: the *disorder* in Gender Identity Disorder. According to Cole, Denny, Eyler and Samon (2005), physicians and psychiatrists have for decades attempted to understand the origins of transsexualism, some borrowing from Freud's theory of gender as learned behaviour, others using male child victims of surgical accidents whose parents were encouraged to raise them as girls as experiments in nature versus nurture. Scientists looked for explanations within the brain and along the genetic code. By the 1970s clinicians had created a number of categories to describe those who were non-normatively gendered, and yet by the following decade these were already found insufficient:

As more members of the transgender community have come to question a system in which there are only two possible genders (male and female), the historical categories of crossdresser and transsexual have become but two of a number of other possible self-identities. (p.151)

According to these authors, as physicians and psychiatrists continued to find discrete categories to label trans people, trans communities blossomed through

words and actions, writing books and creating their own organizations without regard to, and perhaps in spite of, the efforts of well-meaning but ill-informed scientists.

A central figure in the history of transsexualism is endocrinologist Harry Benjamin, author of *The Transsexual Phenomenon* (1966), who was a pioneer among medical professionals, and one of the first to speak publicly in support of GRS for transsexuals in the mid-1960s. His statements against psychotherapeutic cures for transsexuals, and encouragement of the medical profession to instead support transsexuals in the gender transition, were groundbreaking for their time (Lev, 2004). What were once the Harry Benjamin International Gender Dysphoria Association *Standards of Care*, first released in 1979, are now the revised *Standards of Care* of WPATH, the World Professional Association for Transgender Health (Meyer, Bockting, Cohen-Kettenis, Coleman, DiCeglie, Devor et al., 2002).

These guidelines are written by, and geared toward, professionals seeking informed recommendations regarding psychiatric, psychological, medical, and surgical management of GID. In the guidelines, WPATH prescribes the role of mental health providers as those who provide education and psychotherapy, diagnose GID, and conduct assessment or readiness for hormones and surgery. For example, they recommend three months of 'real-life experience' (RLE) in the affirmed gender before prescribing hormones. Another requirement is mental health assessment of transgendered status prior to any surgical procedures, one that places providers and surgeons in a power position as 'gatekeepers' and ostensibly forces trans men people to 'prove' their trans-ness. This assessment ideally incorporates reasonable use of professional judgment that will 'do no harm' when conducting the necessary 'due diligence' with any patient seeking medical treatment, however, the reality remains that this does place mental health professionals in a power position. Treatment guidelines available from the Transgender Health Program at Vancouver Coastal Health (Bockting, Knudsen and Goldberg, 2006) have some of the same limitations while offering useful suggestions for clinicians to mitigate the power imbalance of their relationships with trans patients. They recommend normalizing feelings about the power imbalance, discussing the systemic nature of the assessment process, and remaining transparent about the

course of treatment (p.B3). More recently, programs such as Callen-Lorde in New York City recognize the benefit that beginning testosterone replacement therapy (TRT) can have on an individual's mental health and, as a result, have moved toward an *Informed Consent Model* with much success. This model requires only an assessment of decision-making capacity and the informed consent to take hormones, thus foregoing the 'lived-experience' requirement (Douglass, 2009).

The medical system focuses primarily on gender-reassignment interventions for trans men, and the co-morbidities of GID (Lev, 2004, Raj, 2002; Smit, 2006). Reassignment options for trans men include TRT and gender reassignment surgery (GRS) procedures, although many opt to forego surgical options (Lev, 2004). According to recently published guidelines from the Endocrine Society (Hembree, Cohen-Kettenis, Delemarre-van de Waal, Gooren, Meyer, Spack, et al., 2009), TRT is typically handled through an intramuscular injection of testosterone, while transdermal and oral forms are also available but more costly. The physical changes caused by testosterone may include growth of facial and body hair, enlargement of the erectile organ (more commonly referred to by trans men as the penis, clitoris or 'clit-dick'), thickening of vocal chords causing the voice to lower, an increase in muscle mass and redistribution of body fat, and male-pattern baldness. To my knowledge, genetic, biological and racial differences in the TRT effects have yet to be studied. Health risks associated with TRT include heart disease, elevated cholesterol, elevated hemocrit and polycythemia, and potential liver damage (especially from oral testosterone). The most common GRS procedures are chest masculinization (commonly referred to as 'top surgery') and hysterectomy and oophorectomy, while less common are genital surgeries such as metoidioplasty, phalloplasty and scrotoplasty (Hembree et al., 2009). In terms of the beneficial effects of testosterone, Newfield and her colleagues (2006) reported from their online survey of 376 FTM that those who had received testosterone had significantly higher QOL score than those who did not.

There are concerns related to mental health and substance use for trans men, though the literature in general about this population is small and contradictory (Lawrence, 2007). Kenagy and Hsieh (2005) report of 69 trans men who participated

in HIV-prevention needs assessments conducted in Philadelphia and Chicago in 1997. Data were collected through one-on-one interviews and based on questions developed through focus groups with trans people. They found that 26.2% of participants had previously attempted suicide and, of these, 52.9% (17 respondents) related this action to their gender identity when they answered 'yes' to the question: 'Did you attempt suicide because you are transgendered?'

Clements-Nolle, Marx, Guzman and Katz (2006) reported findings from participatory action research on HIV prevalence conducted in 1997 with transgender communities in San Francisco that may help us understand the state of mental health generally among trans men. Of 586 total participants recruited through trans-identified outreach workers, 123 were trans men. Of these participants, 24 (20%) had a lifetime history of mental-health hospitalization, 39 (32%) had a previous lifetime suicide attempt, and 68 (55%) were depressed based on the Center for Epidemiologic Depression Scale (CES-D).

The mental health literature regarding trans people is highly problematic. As Anne Lawrence (2007) states, the assessment of this literature shows conflicting results wherein some find elevated levels of psychopathology, while others find little or no difference in incidence rates compared to population norms (p.489). Attempts to interpret these reports are made more difficult by the generally small sample sizes of many studies, and by methodological problems such as a lack of standardized psychiatric-assessment tools. The issue I take with Lawrence is that while she recommends bringing a critical lens to the literature, the lens she uses herself is limited to methodological issues and does not capture the essence of trans-affirming feminist perspectives.

The work of Maria Lobato and her colleagues (Lobato, Koff, Manenti, Salvador, da Graça, Petry, et al., 2006) requires just such an analysis. The authors attempt to provide a profile of transsexuals in Brazil by describing only the patients who sought treatment at their university-based gender clinic. This excludes those individuals who might choose to only pursue TRT and do not wish to undertake GRS. The authors state that their "Gender Identity Disorder Program" had seen 138 patients, all of whom were enrolled in the study and, while informed consent was

given, no mention was made of how the researchers avoided coercion in terms of access to services. They state in the abstract that 88.4% were “male”, thereby disrespectfully describing trans-feminine participants by their natal assigned sex rather than by their affirmed gender. The authors describe transsexualism as a “highly disabling condition,” which may be representative of cultural differences in Brazil and therefore true for participants in their particular study; however this is counter to the evidence in Lawrence’s (2007) review of the literature, and that done more recently by Peggy Cohen-Kettenis and Friedemann Pfäfflin (2009) who stated that in many, but not all, studies transsexuals “generally function well psychologically in the non-clinical range” (n.p.). Further, the findings of focus groups conducted earlier in 2009 by Callen-Lorde Health Center in New York showed that participants reacted vehemently against this conceptualization of distress in trans people’s experiences (Douglass, 2009).

The Lobato paper describes the sole components of treatment for transsexuals as psychological support and GRS and, in so doing, calls attention to professionally-mediated interventions over the trans person’s subjective journey through transition. Interestingly the Brazillian paper describes high incidences of psychiatric problems and GID co-morbidities among trans women, but the lack of trans men in the study (16, or 11.5%) undermined their attempts at achieving statistically-significant findings in the transmasculine group.

There do seem to be some issues that Lawrence (2007) states are “plausibly linked to the psychological, social, and economic consequences of living as gender-variant persons in an intolerant society” (p.493), including mental health problems, suicide and self-harm, violence, and risk for HIV infection. The links to the aforementioned issues, according to Cohen-Kettenis and Pfäfflin (2009), include social stigma, difficulties of accessing healthcare and loss of social supports, in addition to the stresses related to subjective experiences of incongruent gender. My interpretation of the Lawrence (2007) and Cohen-Kettenis and Pfäfflin (2009) reviews of the mental health literature suggests that the predominant problems trans men face seem to be socially-determined *DSM-IV-TR* Axis 1 disorders such as depression and anxiety.

There is recent evidence to suggest that transition-related health interventions such as hormone therapy and gender reassignment surgeries improve mental health outcomes for trans people. The previously mentioned report by Newfield and her colleagues (2006) states that TRT independently predicts higher QOL scores ($p < 0.01$) for trans men in the domains of Social Functioning, Mental Health, and Mental Health Summary, and what they describe as marginal statistical significance ($p < 0.05$) in the Vitality and Role Emotional domains. Meier and Fitzgerald (2009), also mentioned previously, found trans men who used TRT had lower scores for depression, anxiety and stress, and increased scores for social support and quality of life. These findings suggest that TRT may play a significant role in the mental health of trans men. Further, van Kesteren, Asscheman, Megens and Gooren (1997) studied mortality and morbidity in 293 FTM people at their gender clinic in the Netherlands. Results showed that “cross-gender reassignment treatment, which has been shown to increase the wellbeing of transsexuals, is not associated with an increased mortality rate” (p.341) and further that “cross-sex hormone therapy is acceptably safe” (p.342). When considered together with Meier and Fitzgerald (2009) and Newfield and her colleagues (2006), TRT is a both safe and beneficial option for the mental health and wellness of trans men.

There is concern about the degrees of problematic substance use based on a small number of studies as well as the potential for risk when compared to other marginalized groups. Cole, O’Boyle, Emory and Meyer (1997) found in their retrospective analysis of gender clinic attendees in Texas that 26% of 117 FTM reported lifetime histories of substance-abuse problems. Further, “[i]n virtually all of the cases, subjects describe their substance abuse problems as associated with their gender dysphoria issues” (p.17-18). This sample had a mean age of 30 years, 83% had already begun TRT and 49% had undergone a surgical treatment (mostly chest surgery), 9% had a history of psychiatric conditions not related to GID or substance abuse, and 21% had attempted suicide. The challenge with a report such as this with a decade and a half of purely historical data is that the reader cannot ascertain whether gender-related therapy, TRT and surgery had any positive impacts and improved the mental health of these individuals. Cuypere, Jannes and

Rubens (1995) found even higher substance-abuse prevalence of 62% among FTMs at their Belgian gender clinic, although with a sample size of only 13.

Dutch findings reported a decade earlier than Cole and colleagues (1997) found different results. Verschoor and Poortinga (1988), in their seven-year retrospective study of 55 'female transsexuals' seeking treatment at a gender clinic, found only 3.8% had previously abused alcohol or drugs; additionally a third had received undefined psychiatric treatment, and 18.6% had at least one suicide attempt. Interestingly, among a literature that is so highly biased toward the deficits of trans people, this study also reported that 55.8% had satisfying relationships with parents and/or siblings, 48% were in stable relationships, and 74.5% were enrolled in school or stably employed.

Kenagy (2002), reporting separately on the Philadelphia data mentioned in a study above, found that 6% of FTMs reported injecting drugs, an area of potential concern in light of cautions published a year prior by the United States Department of Health and Human Services (Substance Abuse and Mental Health Services Administration, 2001) regarding the use of injectable hormones as potentially increasing risk for hepatitis C, and the risk for injectable substance abuse relapse. Further, the potential for liver damage from ongoing hormone treatment is exacerbated by concurrent drug and alcohol use.

A prominent and yet problematic argument in the literature concerns itself with the comparisons of prevalence figures for mental health problems and substance abuse among trans people and lesbian and gay people. Hughes and Eliason (2002) hypothesizes that because trans people experience even greater stigma, violence, and marginalization than do lesbian women and gay men, trans people must also use alcohol and drugs at least at equivalent levels. Lawrence (2007) makes a similarly problematic argument that suggests gay and lesbian people display a comparable gender variance to trans people and thus both groups should experience similar health disparities. Unfortunately this argument is based on the conflation sexual and gender identity described previously by Forshee (2008).

Whether looking at the conflation of sex and gender in the medical literature, the ongoing pathologizing of trans people, or the non-affirming language, the

resulting psychiatrically-defined trans identity can only be described as problematic and unhelpful to trans people. While I acknowledge a certain utility to the mental health literature, I use it cautiously as an indicator of where issues for trans men may exist, while being critical in my analysis of any findings. My findings challenge or contradict this literature on a number of levels. More useful are the models of identity development created by Devor (2004), Lev (2004) and Hansbury (2005), described previously, that are supported in the data from this study.

Social Work Practice in relation to Trans Issues

Social workers can provide pivotal direct services such as counseling, case management, advocacy, and coordination of care. These services are offered through roles in community mental health settings, acute care in hospitals, and legislated agencies such as child-protective services. Within these settings social workers are also in a position to influence policy and practices that affect persons who have or may be vulnerable to mental health disorders. We can advocate for social change for trans people within trans and non-trans communities.

Role of the social worker in transgender mental health. Sophia Pazos (1999) provides general guidelines for how social workers can be allies to our trans clients. We do so by increasing our cultural knowledge of trans communities, using a psycho-education to explain how gender identity disorder may or may not impact mental health and thereby dispel transphobic stereotypes, and generally have an understanding of, and patience for, trans clients who may demonstrate resistance to our interventions due to negative experiences with previous service providers who may have attempted to discourage cross-gender behaviours.

Asking the Right Questions 2: Talking with Clients about Sexual Orientation and Gender Identity in Mental Health, Counselling and Addiction Settings (Angela Barbara, Gloria Chaim, Farzana Doctor, and the Centre for Addictions and Mental Health, 2007) is a helpful guide recently developed in Toronto together with a day-long training for mental health and addictions treatment practitioners. The authors describe two phases of intervention: a one-page assessment completed by clients to describe their sexual and gender identities, and a set of eight open-ended interview items intended for use during assessment or early in the counseling

process as a means of informing case planning. They also provide information about identity-related language, additional probes, and plenty of resources that providers can access. First developed in 2004, the authors evaluated the efficacy of the tool through the post-training feedback forms and telephone interviews. The mental health providers who had been trained to use the guide said it raised their awareness, helped them feel more open and sensitive to sexuality and gender issues, and provided a vocabulary with which to speak to clients (p.2).

The one-page assessment includes four questions. The first inquires about current relationship status, the gender of current and previous partners, length of relationship, and the significance of that relationship to the client; numerous gender and sexuality options are available, including a blank. The second question asks the client to identify their sexual orientation, again with a multitude of options, and then asks if the client has any concerns or awkwardness in this area they would like to address. The third question is structured the same way as the second in asking about gender identity, with many options and a query about concerns and awkwardness. The final question asks: "Is your reason for getting help (substance use, mental health concerns) related to any issues around your sexual orientation or gender identity?" The form makes an effective statement to trans and non-trans, queer and non-queer people that the agency or practitioner is aware of and interested in providing service to a diverse clientele. For the healthcare provider, the form provides sufficient information to begin conversations along the sexuality and gender continuums, particularly when clients identify these as areas of concern or discomfort.

The eight interview items are more exploratory in nature, delving into issues that the literature has identified as potential areas of mental health concern. The first seven explore experiences of discrimination, age of first awareness, degree of being 'out' in social and professional realms, community involvement, body image and HIV. The final question asks about the use of substances to cope with the previously mentioned issues, and/or whether the mental health issues presented are similarly related. Each is presented as applicable to both sexual and gender identity, a strategy that is effective in broadly shifting practitioner awareness to these issues.

This broadness may also be a limitation in terms of addressing trans-specific issues regarding, for example, the personal impacts of internalized transphobia. To their credit the authors introduce Devor's model of identity development as a model to understand the 'coming out' process of transgender people, although the language suggests 'coming out' and transition are for some people one in the same.

According to Cole, Denny, Eyler and Samons (2000), social workers can intervene using two particular strategies. First, we can engage with trans clients with regard to preventative medical care, and build understanding that bodies in transition are only as healthy as the care that is taken with them. As they state: "It is necessary to take care of a body part for as long as it is a part of your body" (p.167). This means addressing the gamut of health issues and behaviours that affect each of us whether trans or non-trans, from smoking and obesity to fitness and mental wellness. And for trans men specifically it means those who retain breast tissue require mammograms, and those with a cervix and uterus require annual pelvic exams. Our second role is to explore and address with clients their histories of interaction within healthcare settings, particularly for abuse or mistreatment. We can then refer clients to practitioners we know to be both welcoming and trained in transgender health. When these physicians, endocrinologists and surgeons require assessments prior to providing medical interventions, social workers along with other mental health service providers may be called upon to provide assessments. In British Columbia, as in other regions, specific individuals may be identified to provide surgical assessment before health insurance will approve coverage, if any. Cole, Denny, Eyler and Samons (2000), Bockting, Knudson and Goldberg (2006) and Lev (2004) explain these assessments at length and in depth.

In British Columbia, a province-wide survey of 179 people seeking transgender health services found that 53% of respondents had need for gender-related counseling, 32% required TRT or GRS assessment, and 39% desired support for issues unrelated to gender (Goldberg, Matte, MacMillan, & Hudspith, 2003). This survey informed the current Transgender Health Program (THP) at Vancouver Coastal Health, the regional health authority. The THP has developed numerous guidelines for provision of care for trans people that cover a wide array of

health subjects including primary care for adults and adolescents, hormone assessment criteria (discussed previously), and speech therapy (VCH, 2009). Their resources also include 18 brochures for consumers of trans healthcare with topics ranging from TRT and surgery to cancer, osteoporosis and cardiovascular health.

In ‘Counselling and Mental Health Care of Transgender Adults and Loved Ones’, Bockting, Knudson and Goldberg (2006) provide clear clinical guidelines for a thorough mental health assessment of transgender clients including clinical pathways, capacity for decision-making, and generally a more comprehensive discussion of assessment criteria within the WPATH *Standards of Care* (Meyer, Bockting, Cohen-Kettenis, Coleman, DiCeglie, Devor et al., 2002). In ‘Social and Medical Advocacy with Transgender People and Loved Ones: Recommendations for BC Clinicians’, social worker Catherine White Holman and her colleague Joshua Goldberg (2006) provide a contextual perspective of practice with trans people cultivated from many years of clinical experience. They caution about awareness of literacy levels and cultural diversity when conducting any assessments. Practitioners are likely to encounter new immigrants, refugees, and those requiring support who do not speak English. Potential life-areas of intervention that can impact mental health include financial assistance and housing, health and child care, and advocacy with regard to housing, employment, or in the change of identification. In some cases we may work with individuals with complex mental health and cognitive concerns, and for whom accessing healthcare can be a difficult task in and of itself.

Lev (2004) identifies three reasons for clients to seek assistance regarding gender issues, the first being those gender variant people seeking medical assessment and referral already described; the other reasons have been far less elucidated in the literature. The second is familial or relationship issues that may require additional support to partners and family members (p.204). Lev offers a model of Family Emergence with four stages: Stage 1, *Discovery and Disclosure*, finds individuals reacting to their transgender loved one with feelings of shock, confusion and betrayal; Stage 2, *Turmoil*, finds family members in chaos and stress as they struggle to accept gender variance; Stage 3, *Negotiation*, has family recognizing the gender issues will not dissipate and reaching compromise about

how the gender expression can be realized within the family unit; and Stage 4, *Finding Balance*, is respite from the turmoil after negotiation and coming to terms with the now-public secret that was transgenderism.

Lev's third reason for clients to seek help is to address gender-related distress. She argues that the fear trans people have for transgressing normative gender behaviours, and the long-term performance of a false self may actually cause mental health issues (p.196). Lev suggests:

The high incidence of mental illness among transgendered people noted in the literature might be better understood as reactive symptomology and posttraumatic sequelae. It is literally *crazy-making* to live a false self. (p.196, original emphasis)

Lev believes that these illnesses might actually be expressions of deep-seated trauma. This approach releases transgenderism and GID as expressions of mental health symptoms and substitutes these with an etiological view of Post-Traumatic Stress Disorder (PTSD), another DSM-IV-TR diagnosis that is familiar to practitioners without the burden of the gender-related stigma. The key, if in fact the foundations of transgender mental health are based in PTSD, is for service providers to explore these issues with their trans clients.

Using a strengths-based approach to social work research. In order to achieve an understanding of individuals' lives, I use a strengths-based model commonly used in social work practice as a lens. As Saleebey (1996) explains:

The strengths perspective demands a different way of looking at individuals, families, and communities. All must be seen in the light of their capacities, talents, competencies, possibilities, visions, values, and hopes, however dashed and distorted these may have become through circumstance, oppression, and trauma. The strengths approach requires an accounting of what people know and what they can do, however inchoate that may sometimes seem. It requires composing a roster of resources existing within and around the individual, family, or community. (p.297)

The shift in thinking here is away from a problem-solving or pathology approach that situates the service provider in the role of expert to one where the social working is

another resource to whom the true experts – our clients – can turn to assist in achieving their self-identified needs. This is not to dismiss the existence of presenting problems, the issues that first bring them to our offices, as these are the reason the client has been motivated to see us. Once client and provider have clarified the issues at hand, Graybeal (2004) recommends they explore the personal, social and community resources the client possesses that could potentially help address the problem. What realistic options does the client see as available? What possible directions are reasonable? When has the presenting problem been less problematic, what was different at that time, and what can the client draw from that experience? And what does the client see as potential solutions?

Saleebey (1996) outlines some of the common critiques of a strengths-based method of practice: it is a guise for ‘positive thinking’, merely reframes misery, ignores reality, or is naïve. However, rather than a superficial reframe of client problems, the strengths-based approach is one that requires skilled practitioners who seek to meet their ethical obligation to be client-directed in all aspects of their social work practice (British Columbia Association of Social Workers, 2003; National Association of Social Workers, 2008). The approach requires social workers to capitalize on clients’ capacities and demonstrated abilities in order to move forward. To do so requires the use of counseling and communications skills to get to the core of client needs and values. We communicate the reality of the challenge, and then help clients develop strategies to work through these. As Cousin (1989) suggests, “one should not deny the verdict (diagnosis or assessment) but should defy the sentence” (cited in Saleebey, 1996, p.303). The answers are found in the stories clients share about their lives and, thus, this model is an effective complement to a narrative research approach, one that elicits from participants stories and then uses these as data for analysis.

This research project falls within a recently evolving movement of researchers, advocates and policymakers who use a wide array of strengths-based approaches. Maton (2004) asserts these groups share a common world-view that seeks to shift away from the deficits-based methods toward explorations of resilience, health promotion, school reform and community development (p.3).

Important to my study of trans men are the authors' suggestions that this approach can help to understand healthy development and the role of resilience; empower those lacking power while strengthening environments; and promote individual development, quality of life and self-advocacy (p.4).

We often say that we only want the best for one another. Parents say they just want their children to be happy. A strengths-based assessment provides a broader context in terms of abilities and capacities within which we can learn what's working and what's not. If we do want what is best for others then I think we are interested in wellness and in physical and mental health that are sufficient to support satisfied lives for trans men. How to achieve this is still not well understood, as indicated by the enormous gaps in the present health and mental health literatures described previously. It is my belief that, by highlighting the strengths inherent within the stories of generally-satisfied trans men, we can begin to fill this gap.

Conclusion

Application of theory, research and practice in this project. Feminist theory assists in the identification of sites of power and resistance between the institutions that have historically provided healthcare and the various oppressed groups; as yet this tension has only been described in a limited way in terms of trans men. Narrative research, which I discuss in more detail in the next chapter, provides an avenue to elicit from participants the stories of their experiences in the everyday world, while honouring agency and subjectivity (Mishler, 1986). By drawing out stories from trans men about how they understand the world, I can recognize and expose how their lives intersect with the hegemonic establishment. The subjective well-being framework explains how everyone assesses their own well-being (Diener, 1984; Ryff, 1989), but to date this approach has not been applied to the lives trans men, nor has it been use to my knowledge as a gauge for confirming the life satisfaction of a participant group.

Transgender identity developmental models, such as those proposed by Devor (2004) and Lev (2004), provide a rough framework that helps those less familiar with trans identity to situate both research and narratives about trans experience within the context of trans lives, but have yet to be applied as a method

of contextualizing the dominant and medicalized literature on mental health and GID among trans people. As discussed, these developmental frameworks highlight gaps in the medical discourse on transgenderism that focuses on a narrow range of identity-development stages, specifically from the time an individual is exploring resources until they undergo medical interventions. The range of stages encompassed by the medical discourse correspond roughly with Lev's (2004) 'seeking information and reaching out' through to 'integration: acceptance and post-transition issues' (Stages 2 to 5), and with Devor's 'discovery of transsexualism and transgenderism' through to 'transition (Stages 4 to 11). Thus, due to the dominance of the medicalized model in the existing trans literature, we know little about the experiences of those who are early in their consideration of gender and those who have completed transition and have developed their post-transition identity.

The Standards of Care and other frameworks for praxis direct social workers toward treatment that privileges the medical transition experience. These lack the capacity to explore foundational psychological impacts that are a result of gender-related stigma. Lev (2004) homes in on key therapeutic issues, and suggests trauma may be at the root of disordered behaviour. What is still lacking are practical therapeutic tools to unearth those traumatic experiences that may impact the mental health and wellness of trans clients, and an understanding of how those experiences affect the lives of trans people who are not mentally ill. An assessment tool is needed, one that can guide the dialogue between client and provider to understand the impacts of these experiences.

By exploring the subjective experiences of well being through a critical, trans-feminist lens, I aim to counter the dominant, pathologizing discourse. My central research question was: what can be learned from the stories of trans men about their mental health and wellness? Further, I endeavoured to understand in which realms of trans men's lives is satisfaction important and/or significant. These are the questions I followed through this research process, and that inform the development of an assessment tool for use by social workers and counselors to address transition-related mental health issues.

3 RESEARCH DESIGN

The Fred Study was a qualitative research project designed to better understand issues that contribute to the mental health and wellness of trans men, and to fill in the gaps of the present literature. Qualitative research is particularly effective to explore new areas of inquiry (Flick, 2002) and, further, allows researchers to create a “complex, holistic picture...of a social or human problem” (Creswell, 1998, p. 15). I conducted two focus groups as informed by Krueger (2009), and individual follow-up interviews using the narrative approach to qualitative research described by Michler (1986) and Lieblich, Tuval-Mashiach and Zilber (1998). To add a slightly different perspective on narrative, I used the strengths-based approach discussed in the previous chapter as a framework to inform focus group questions, data collection and analysis of the data. I also incorporated a component of qualitative description. These methods combined were, in my opinion, the most effective methods to elicit the stories that trans men share about their mental health and wellness, and understand how they self-assess for life satisfaction.

In this chapter, I discuss how I applied a narrative lens and strengths-based approach to both the research design and inquiry strategy in order to answer the research questions. I describe the process I undertook to conduct this study so that the reader has a better understanding of the concepts and decisions that form the foundation of this work. I present the sampling methods, recruitment issues, explain how data were generated and analyzed and, finally, validity issues.

Qualitative Research and the Use of Narrative

Qualitative research holds a number of characteristics that provide the researcher unique opportunities that other methods of inquiry may not. Creswell (2008) highlights a number of these: the ability to meet with participants in their natural settings; availability of multiple methods of humanistic interaction between researchers and participants; flexibility to adapt and refine inquiry based on real-time data collection; interpretability of data through the personal, and often critical, lens of the researcher; and a holistic vision of social phenomena that more closely resembles the complexity of social interactions. In contrast to research that

promotes itself as objective, throughout the qualitative research process the subjectivity of the researcher is ideally both identifiable and transparent. These qualities are what drew me to qualitative research.

As previously stated, the research questions were:

- what can be learned from the stories that trans men share regarding life satisfaction, mental health and wellness
- what realms of their lives did trans men see as significant to their well-being

This emphasis on the participants' stories was the strongest motivation to use a narrative approach that would give voice to the experiences of participants.

I chose to take a narrative approach to this study as, from an epistemological perspective, I argue that the stories people share are rich with meaning, and that we can better understand one another through the interaction of telling and sharing stories, in the interaction. Narrative inquiry (Lieblich, Tuval-Mashiach & Zilber, 1998) refers to an array of qualitative research approaches that undertake analysis of the content of the interview as well as its form. According to Mishler (1986), by focusing on the stories participants' share about their lives, a researcher can better understand the storyteller as an individual as well as a person within a particular group of relationships and social dynamics. Participants will commonly share stories from their lives that speak to and answer the research questions. He advocates a relatively unstructured approach to interviewing in which participants are asked about their experiences and allowed to respond with minimal intrusion by the interviewer. In terms of clinical mental health practice, narratives allow people to make meaning of their lives, particularly difficult or threatening experiences, by creating reasoned stories (Joseph & Linley, 2005); this story creation often leads to resolution of these experiences within the greater life story and the capacity to develop and grow from them (Pennebaker & Seagal, 1999). My intent was to capture these essences in the data.

Mishler (1986) encourages researchers to look at how stories are constructed within the interview in terms of temporal sequence and use these to inform answers to the research question and also to understand more about the participant's identity. In some cases, even the 'story' of the events of the interview can be

analyzed from a narrative perspective to provide insight into how the participant and researcher co-create meaning of the research inquiry.

Lieblich, Tuval-Mashiach and Zilber (1998) encourage exploring “the narrative as a whole,” and to contemplate gender and the role it plays while a narrative is being constructed, told and analyzed (p.89). This includes: identifying themes that influence the story, be they of progress, decline or steady movement; and locating particular language from the participant to help situate the storyline. I applied this narrative approach, and the strengths-based approach, to the design, execution and analysis of my study in concrete ways that I discuss further in the next section.

My analysis was also informed by qualitative description as described by Sandelowski (2000), particularly in regard to the thematic assessment of the focus-group data. She explains qualitative description as “a comprehensive summary of an event in the everyday terms of those events” (p. 336). Sandelowski explains further that qualitative descriptive studies seek to ensure “an accurate accounting of events...and an accurate accounting of the meaning of those events” (p.336). She states that the approach is particularly useful to graduate students as it allows for greater flexibility while learning research methods without the need to mould the study into a discrete category or framework like phenomenology or grounded theory. The process I used for reviewing transcripts, reading them like a novel, and then re-reading and coding for emerging themes followed that described by Hsieh and Shannon (2005). I provide further detail on how I conducted this analysis later in the chapter.

Data Generation

In order to better understand the experiences of trans men in terms of mental health and wellness, I engaged with participants using more than one method in order to increase the richness of the data (Maxwell, 2005). Hearing individual stories seemed equally important to hearing what participants would share in a group setting. I theorized that individual interviews would allow me to converse one-on-one with participants, while focus groups would provide the opportunity to listen in on what participants would share with one another. I also invited an Advisory Group of trans men to consult on the project in order to address any concerns about my being

a non-trans person and academic social worker conducting research within trans communities.

Use of focus groups in qualitative research. According to Padgett (2008), focus groups originated in sociology and were developed to benefit product-marketing efforts and to inform election polling. A method unique to qualitative research, she states that focus groups create a venue for “elicitation of insights from individuals stimulated by the group dynamic,” and that they are “particularly well-suited to studies and organizations or communities where there is a web of social networks already in place” (p.103). What makes a focus group particularly effective is its ability to foster a more conversational environment, one that encourages participants to ask one another follow-up questions or comment on statements of others, an outcome described by Stewart and Shamdasani (1990) as the “synergistic group effect” (p.43). Krueger (2009) expands on this idea, stating that a focus group “possesses the capacity to become more than the sum of its parts, to exhibit a synergy that individuals do not possess” (p.24). In this study I used a single-category focus group design that Krueger (2009) describes as a method for gathering the views of the most information-rich participants.

Researchers have previously demonstrated the value in recording and reporting narratives of disadvantaged and oppressed groups. Ester Madriz (1998) writes about the efficacy of using focus groups in her study of lower-socioeconomic-status Latina women. She points to the desire of feminist scholars to critique the more traditional research methodologies, particularly when studying women and especially women of color and of lower socio-economic status. This critique by feminist scholars has resulted in a larger literature that focuses on women’s stories, including in-depth interviews and testimonies to narrate the everyday reality of these women. Focus groups allow researchers to listen to the voices of participants, and contribute to the validation of their experiences by others of a similar experience. Focus groups become a form of collective testimony where participants are able to exchange, verify and confirm their experiences with others. As Pilar Riaño-Alcalá (2006) states: “When a group collectively explores its past through the sharing of stories, the practices of memory often cover a continuum between description,

sensorial experience, and analytical reflection” (p.17). Madriz (1998) states that the interactions within focus groups emphasize empathy, commonality of experiences and foster self-disclosure and self-validation. Just as Madriz states that the narratives she heard in her research challenged the traditional representations of Latina women, I used focus groups as an opportunity to hear the collective testimony of trans men and challenge the dominant narrative of their experience.

From a strengths perspective one can see that the testimonials that come from focus groups can be an effective way of documenting not just the challenges and difficulties that trans men experience, but also the “multiple strategies of defiance and resistance” that operate therein (Madriz, 1998, p.125). According to Madriz, the flexibility of a focus group allows the complexities of race, gender and class differences to surface making it “a culturally sensitive information garnering method,” (p.125) and therefore suitable for this study of trans men. She further states that focus groups “provide a non-threatening atmosphere” (p.125) in which participants can speak and have their voices listened to and self-validated, and that focus groups are an appropriate methodology for interviewing participants when the researcher’s interest is to share the voices of participants as a way to promote social justice and political change. She does not suggest that focus groups are the ultimate way of collecting these data, but that focus groups are more conducive than others to meet these goals and that they offer a provocative and unique way of listening to collective narratives.

Use of unstructured, narrative interviews. According to Fontana and Frey (2005), unstructured interviews “attempt to understand the complex behavior of members of society without imposing *a priori* categorizations that may limit the field of inquiry” (p.706). This is a significantly different approach than structured interviews that try to collect code-able, systematically collected data that fit discrete and predefined categories. The authors point to the importance of language, particularly the creation of a “sharedness of meaning” from which both the researcher and participant(s) “understand the contextual nature of specific referents” (p.660). This framework would prove to be significant in my communications with trans men.

Mishler (1986) encourages a looser structure for narrative interviewing where participants are allowed to speak freely, much like the conversational approach I described for the focus group; the researcher should feel confident that somewhere within the narrative arc the response or answer to the research question will be found. O'Neill (2002) speaks of giving participants as much control as possible in the interviews, inviting them to reflect on their feelings, and elaborate on their responses (p.80). He also discusses the value of disclosing personal experiences that are similar to those of the participant in order to create a more conversational atmosphere (p.84). These strategies are intended to create an environment where participants can share more freely their stories of wellness and contentment.

Combining focus groups and individual interviews. Conducting focus groups and one-on-one interviews together in the same study is one of the most common research combinations, and the most straightforward since both are qualitative methods (Morgan, 1996). Morgan states that the former offers greater breadth on a subject, while the latter provides more depth. As Bruce Berg (1989) has noted, the two approaches have different advantages for yielding rich data. Focus groups offer researchers the ability to observe interactions about a discussion topic, how participants relate and share outlooks and experience, and how they explore these issues, while traditional interview styles allow a more detailed pursuit of content information. Berg states, “[t]raditional interviewing approaches...sacrifice the ability to observe interaction for greater amounts of detail on various attitudes, opinions and experiences” (p.89). Since I see both kinds of data as important to the study of gender and identity, I chose to combine these two complimentary methods.

For this study I conducted two focus groups and eight individual follow-up interviews. I considered in which order I would conduct interviews and focus groups and there were strong arguments for both alternatives depending on the needs of the research study (see Morgan, 1996). By conducting individual interviews first and focus groups second I could use the focus group to get a broader perspective on themes and issues generated from interviews. Instead, I decided to hold the focus groups first. In this way each of the two focus groups generated its own themes that I used to generate questions for follow-up individual interviews. Observation of

participants highlighted the issues that generated laughter and head nodding that would not necessarily be evident in the focus group transcripts. In anticipation of just this kind of rich observational data, and the possibly synergistic and emancipatory experiences discussed earlier, I enlisted a volunteer research assistant, a non-trans and culturally-competent trans ally.

The role of the Advisory Group. Early in the development of this research project I had concerns about being an outsider to trans communities and believed it was vital to ensure that this position was not the sole perspective on the research data. I had read that O'Neill (2002) had used advisory groups of gay men in his study and thought this would be a useful strategy. For this reason I invited two trans men to join with me on the project as an Advisory Group to provide feedback on the research questions, recruitment, and to comment on my analysis, and to provide as well as their insights on some of the stories participants shared. These men hold Graduate degrees and work in professional mental health positions. According to Karen Healy (2001), a Sydney-based social worker, creating opportunities for participation in research is an opportunity to raise awareness of issues critical to marginalized people as well as encouraging these groups to respond collectively to oppression (p.96). Healy states:

Through involving oppressed people in knowledge building, participatory researchers seek to create more holistic understandings and better maps for changes than is possible through traditional science or, indeed, unreflective forms of activism. (p.95)

Co-creating knowledge in this way can be a rich experience for participants, community members and the researcher, and it strengthens the findings of this study and addresses some concerns about validity.

Patricia Kelly (2005) acknowledges there are some challenges to conducting more participatory processes of research in terms of balancing a meaningful process with the need for measurable outcomes (p.70). These can be significant issues especially for a Masters-level graduate student with a short timeframe to complete a thesis. While I felt the pressure of Kelly's words, due to the small size of the Advisory Group and their willingness to participate, I did not find this to be an issue in my

research. I did develop findings from the study fairly quickly in part because people were willing, able and eager to participate in the interviews and Advisory Group

Sampling and Recruitment

I enlisted eight participants using purposive criterion sampling, a strategy wherein the researcher identifies the locations and individuals who might best help answer the research question (Creswell, 2003). Trans men I had met over the course of developing this study, who were active and well connected in Vancouver trans communities and who expressed interest in supporting the project, helped me to identify participants.

Recruitment materials were provided to the recruiters. The promotional materials asked: “Are you a trans guy? Are you generally satisfied with your life? We’d like to hear the story of your journey” (Appendix A). Implicit in this call to participate was that individuals self-identified as trans men and had subjectively self-assessed their own life satisfaction. Participants were also required to be at least 19 years of age and able to provide informed consent.

Recruiters contacted individuals they believed were suitable candidates for the study by email and telephone, providing both a description of the study as well as a personal testimonial of my competency and sensitivity as a trans ally. Madriz (1998), in her recruitment of lower-socioeconomic-status Latina women, similarly used personal networks and community leaders to connect with prospective participants and provide testimonials that her approach was both culturally sensitive and appropriate.

Prospective participants contacted me directly by phone or email. Most declared their eligibility up front, and many posed questions about my intended use of the data, in what seemed like a test of my cultural competency. They asked how I would be reporting the data back to the community that informed the study, and what was my role and investment in the work. After responding to their questions in a satisfactory way, I informed participants they would receive a \$10 honorarium for attending the focus group, and an additional \$20 for the follow-up interview. I advised participants that they would have the option to review and revise transcripts from both the focus group they attended and their individual interview; no

participants requested transcripts, although one individual requested at his interview to revise a response he gave at the focus group

Due to the small size of trans men's communities, I recognized it was impossible to guarantee anonymity to participants. I made full disclosure of these risks at first contact, in the approved written consent form (Appendix B) I sent a week in advance of the focus group, and at each meeting. Understanding this, participants provided informed, written consent to participate in one of two 90-minute focus groups and individual follow-up interviews, all of which were completed in March and April 2009.

Data Collection

Focus groups were scheduled based on each participant's availability and I asked them to bring along "a personal object or memento that represented their journey" to share at the focus group. I intended to use the item as a tool to set a tone of storytelling within the group. Regarding the value of these kinds of personal objects, Alan Radley (1990) states: "In the very variability of objects, in the ordinariness of their consumption and in the sensory richness of relationship people enjoy with them, they are fated to be later re-framed as material images for reflection and recall" (p.58). The items that participants brought were intended to provide a material focus for the sharing of stories and, as expressed by Riaño-Alcalá (2004), "a dynamic site of individual and collective memories" (p.220).

Two focus groups were held at the offices of the Health Initiative for Men (HIM) in Vancouver, BC. Three people participated in the first group and five in the second without overlap. In each focus group session, I first reviewed the Consent Form and obtained signatures from each participant. I then discussed the parameters of confidentiality, and reminded participants that participation was voluntary, that they could decline to answer any question and could withdraw their consent and participation at any time. I facilitated the discussion based on open-ended questions and probes that used the strengths-based approach described earlier to elicit personal stories (Appendix C) while my research assistant kept track of speakers in order to assist with transcription. After the focus group, I took field notes.

In the interview guide, the first question asked was, 'What brought you here to this research focus group tonight?' I believed this would be both easy to answer and also begin forming a sense of commonality among group members. The second question asked participants: 'Describe for the group the item you've brought with you and how it represents your journey. The third and fourth questions asked: 'Who are the support people you have in your life?' and 'What resources do you have available?' Graybeal's (2004) pragmatic guide to strengths-based practice for social workers informed these final two questions. While at the first focus group I asked these questions in their intended order, in the second group I unintentionally skipped the first question and then reintroduced it as the third question; all other probes were used in order.

Within two weeks of the focus groups, participants attended an individual interview at a location of their choosing. In one case this was at the HIM office, while for the remainder it was in participants' homes. At each interview, I again reviewed the Consent Form and reminded them of their right to opt out of the study or decline to answer any question. In advance of each interview, I developed individualized probes to address two categories of issues: topics discussed within the focus group in general about which I sought further information, and those mentioned specifically by the individual. I used these probes solely to inform the conversation, not to guide or direct it in keeping with Mishler's (1986) desire to remain conversational and trust the answers to research questions would be expressed. I audio-recorded the interviews and took further field notes.

A professional transcriber transcribed verbatim both the focus groups and interviews, which I then checked for accuracy by comparison with the recordings. I advised the transcriber to use a pseudonym for each participant, and instructed that no proper names be included in the transcripts. In my review of the transcripts, I removed what I considered to be identifying information and, in two cases, consulted with participants to gauge questionably identifying information.

Sample

Eight participants, aged 25-48 years, took part in this study, all of whom self-reported being “generally satisfied” with their lives. All participants reported being post-transition within a range of 9 months to 8 years, although they used different criteria by which to measure the end date. All participants resided in the Vancouver area. Three participants self-identified as black, Asian, and Canadian-Aboriginal, respectively, while a fourth was living with a physical disability. Some were employed, others on social assistance or attending school. Due to the small size of trans men’s communities in Vancouver, any more detailed participant demographic description risks revealing their identities.

Data Analysis

After each focus group, I met with my research assistant to debrief and reflect on what we had heard, taking notes of emerging themes and the stories that stood out for us. Following the focus groups and interviews I listened to the audio recording on its own in order to collect further impressions based solely on auditory engagement with the data. I listened a second time while reviewing the written transcript. The corrections I made were for hard-to-hear sections and some trans-specific terminology with which the non-trans transcriber was unfamiliar. In some instances I changed the punctuation to better reflect my interpretation of a speaker’s tone and intent. I then reviewed the transcripts, made notations and collected my ideas about a few important stories in my research journal.

Next, I conducted a broad, thematic analysis of the focus group transcripts as described by Hsieh and Shannon (2005) to identify stories participants shared that fit the strengths-based questions I had developed. From this process four themes emerged which I used as a framework to explore stories contained in the individual interviews. These themes are described in Part 1 of the Findings chapter.

Once I had developed preliminary ideas about the data, I met with the Advisory Group, bringing along anonymized excerpts from selected transcripts for their review. The Advisory Group provided insights and ideas that contributed to a deeper analysis of the unique stories from participants. I then developed three stories from three participants that fit with the grand narrative that I saw emerging

from the data. The collection of these stories and their analysis is the substance of Part 2 of the next chapter.

Consistent with Mishler (1986), I then identified each participant's core narratives, looked at the sequence of events that exemplified the main point of each account, and examined this story to understand the social interactions among the characters. Next, I looked for clues that revealed the storyteller's identity and assessed the impact of the interview context on the form and content of the account.

Ethical Issues

A number of ethical issues needed to be addressed prior to embarking on this research project, ones that impacted recruitment, consent and participation. My first concern was related to maintaining confidentiality and the small size of the trans men's communities. The Advisory Group made it clear that transparency is always the best way to address this issue and this was in line with privacy and confidentiality issues as required by the UBC Behavioural Research Ethics Board; participants had provided voluntary consent, and were given the opportunity to withdraw at any time. The small size of the community did mean that it was easier for third-party recruiters to identify and reach prospective participants. I was clear with the recruiters, as per approved research guidelines, that I could not reveal to recruiters which individuals had actually participated in the project. Despite this, it was clear from conversations I overheard in the community that participants had themselves disclosed to the recruiters and other community members their participation in the study. Regardless, I have maintained my ethical responsibility not to discuss or confirm who may or may not have participated in the study.

I undertook a further measure to protect participants' confidentiality. I assigned a pseudonym to be used during transcription and instructed the transcriber to only use this pseudonym and never participants' real names when and if it occurred within the audio recording. Then, for this thesis document, I generated another set of pseudonyms to further distance the stories of participants from the transcriber.

Another ethical issue concerned the potential of sharing participants' stories with Advisory Group members to reveal participants' identities. I advised participants

of this possibility and asked Advisory Group members to let me know if this was ever the case. Indeed such a situation did occur at which point I reminded the Advisory Group of their confidentiality agreement and asked if that member could continue participating in that conversation. In this instance the group member was able to continue in our discussion. To ensure confidentiality of the participant, at no time did I reveal whether the association the Advisory Group member made was accurate or not. This situation provided an opportunity for the group to review and re-emphasize the importance of maintaining the ongoing confidentiality of participants in this study.

Validity Issues

Maxwell (2005) describes validity as “the correctness or credibility of a description, conclusion, explanation, interpretation, or other sort of account” (p.106). Maxwell asserts that qualitative researchers must consider all potential validity threats and having done so, the researcher can then identify strategies to rule these out. He states that there are two primary threats to validity, including ‘researcher bias’ wherein the researcher makes the data fit a particular theory or subjectively selects data of particular interest; this is controlled for by the researcher making explicit their biases and the social locations that inform the way they see the world. For example, as a non-trans man, a queer-identified person, and a researcher I bring particular perspectives to this work. Throughout this process and within this document I have been as overt as I am able about these lenses and the ways they may help or hinder my understanding of the data. The second primary threat to validity is reactivity, meaning the ways in which the researcher’s presence affects participants’ behaviour and responses. While, according to Maxwell (2005), this is a less serious threat than most believe, it remains important for researchers to be reflexive about what influence they may have on the participants (pp.108-109). Using open-ended questions, like those in the strengths-based model, is one approach I took to mitigate the effects of reactivity.

Strategies offered by Maxwell (2005) that address validity concerns include respondent validation wherein the researcher solicits feedback from within the group being studied. This can be achieved by collecting data from the same participant on more than one occasion, and by asking participants and other members of the study

group to provide their reflections on the data. These reflections are not without bias themselves, but rather contribute to the evidence of validity. The use of focus groups and follow-up interviews is one way I have addressed this concern. Another strategy, intervention, involves describing the effects of the researcher on participants and their environments just by conducting the research; in some cases, researchers may also intentionally alter their approaches to different participants to see how reactions may vary. I reflect on my success at countering these threats to validity in the last chapter of this report.

Krueger and Casey (2009) address validity issues specifically related to focus groups. They suggest the research personnel who engage with participants are appropriate in terms of experience, training and sensitivity to the issues at hand. Further, they recommend considering both textual and observational data together, and member checking any interpretations, which means soliciting feedback from participants on the analyses. David Morgan (1997) adds that using appropriate and comprehensible language both improves validity and reduces unreliability by limiting discrepancies in how participants understand the questions. Morgan states that focus groups are limited by their intent to answer the researcher's questions, and are thus not naturalistic, although the same can be said of many other research methods, both qualitative and quantitative. Discussion may be limited based on the experience individuals have with the specific topic matter resulting, perhaps, in some participants talking more than others. Again, a good moderator can help ensure everyone who wants to speak has that opportunity, while having a follow-up interaction like an individual interview creates an opportunity for the researcher to check in with all participants.

Individual interviews have their own validity issues. Barbara Jane Elliott (2005) states that they have the benefit of being more accurate, truthful and noteworthy than structured interviews due to the focus on allowing the participant to lead the conversation. By using their own vocabulary and frameworks to discuss their lives, participants can more accurately reflect their experiences, thus increasing the internal validity. Elliott (2005) writes that measuring external validity is much more challenging:

If narratives become the focus of research not simply because they provide an insight into individuals' experiences and the meanings they make of them, but because their form tells us something about the cultural framework within which individuals make sense of their lives, then the close analysis of narratives produced by a relatively small sample of individuals may produce evidence that is considered to provide understanding of the intersubjective meanings shared by the whole community. (p.28)

In this case, researchers must describe effectively the boundaries of particular communities their claim proposes to represent, so that the reader can assess the degrees of intersubjective relationships.

In order to minimize threats to validity, I incorporated a number of specific strategies. Interviews were audio-recorded, transcribed verbatim, and the resulting transcripts were reviewed against the original recordings for accuracy. I collected field note throughout the study and specifically during and after each participant interaction. When necessary, I conducted member checks to ensure accuracy of my interpretations.

Limitations

My choice to conduct focus groups was a decision that structurally prevented a guarantee of anonymity because, as a researcher, I can only request confidentiality and non-disclosure, but I have no way of enforcing it once participants leave the room. It is possible, perhaps likely, that some individuals who were approached to participate in this study may have declined because of this methodological choice, even if no prospective participants overtly identified this as a barrier to the recruiters or myself. This may have resulted in the voices of potential participants with diverging views not being heard.

All participants described themselves as being post-transition in temporal terms of at least nine months and up to eight years. Their perspectives on transition are in hindsight and therefore may not represent those trans men who are contemplating or in the process of transition. It is possible that trans men who were in transition at the time may have selected themselves out of participation because perhaps for some the term "satisfied" itself may have implied completion of

transition; stories of participants in this study suggests that this may not be the case in that some described their transition experience as being enjoyable.

I must consider who was accessed through third-party recruitment, and whether the connection of these individuals to recruiters who were more community-active trans men may suggest a more politicized viewpoint on the part of participants. Also, considering the urban location of the study, it is likely that the views will not reflect those of trans guys residing in rural areas.

Conclusion

With the understanding of how and why data were collected and analyzed in the way they were, in the next chapter I present findings from the research study.

4 FINDINGS

This study was focused on exploring the narratives that trans men share about their mental health and wellness and how they assess their life satisfaction. In this chapter I share findings from my analyses of data collected during two focus groups and eight follow-up individual interviews. In Part One, I discuss broadly four primary themes that emerged from the focus groups and were consistent throughout the individual interviews. Then in Part Two, I provide in-depth studies of three participants' narratives in order to illustrate, illuminate and provide greater context for the broader themes, and how they answer the research questions.

Part One: Thematic Analysis

In this section, I report on four themes that emerged from the data. In the first, I share some of the ways in which participants demonstrated how their efforts at managing early transition demonstrated self-efficacy, a key factor in a satisfying transition experience. Next, I discuss how hearing positive stories from previously-transitioned trans men offered hope during transition. Then I describe how personal supports and resources directly impacted the 'success' of transition. Finally, I show how these trans men charted their own courses to satisfaction.

The importance of transition in the lives of trans men.

Transition experience was rather significant for the participants in this study and, within this, several issues relating to early transition stand out such as realizing they are trans, connecting with other trans people, the importance of 'passing' or being read as a man and how this experience can be different for those with other marginalized identities.

Participants each described in their own way how they first self-acknowledged being trans. Half of the participants indicated they were aware of a gender disharmony or of being male since childhood or youth, while just as many others came to this realization in their early to mid-twenties. While there was no consistency among participants about the length or context of their early gender ruminations, each did speak of a moment or epiphany when they recognized a desire for exploring gender and this was the impetus for beginning their transition journey. As one participant explained:

If this is my truth, if this is what I lay in bed on a Saturday morning fantasizing about doing if I won the lottery, then what's really stopping me from doing it? And yeah, I haven't looked back.

This participant provided a standard with which an individual might measure their desire for an important decision in life. This is a scene most people can relate to, inviting us to consider what we might dream for ourselves if afforded that same space to daydream. For this participant the persistent truth remained the same in that he wanted to transition and he used this time to reflect on and affirm his decision to do so. Based on the smile on the participant's face as he spoke these words, he was happy he followed through with his decision.

Another participant spoke differently about his gender epiphany and decision to transition:

And so I was a girl for a while and I was okay being that. There wasn't any problem but I knew there was something else for me to explore, right. So when I was 33, I just kind of thought: "Well, okay, I think I'm done being a girl. Let's go be something else." And that's just what I did. It wasn't some horrible traumatic thing from the past with gender dysphoria. It just was what it was: I always wanted to be a boy, sure. [And] I didn't kind of give myself a hard time about it either.

This story counters the dominant medical narrative that there must be long-term struggle or anxiety about gender. This participant normalizes the experience as just another option to be considered and goal to be achieved. Clearly we must not make any assumptions about how these trans men first came to recognize their trans-ness.

In the early stages of transition, many participants sought out others with similar revelations at support groups, which arguably put them in a privileged position over others who did not have similar access. One participant referred to a popular Vancouver support group as "a weekly or a monthly bitch session" where attendees spoke only about what was hard in their lives and the issues with which they were struggling. What became clear was that participants were not averse to the people attending the groups, but rather to the negative tone and content of

discussions there. One participant described his experience very clearly: “I ended up hating going to the group later on because of the negativity.” This individual described attending a support group for trans men for a number of months until he finally stopped. He, like many others, described his frustration at hearing what was not working for support group attendees, and rarely hearing any solutions. Another participant said:

I feel like if there had been other kinds of [stories] out there. Not to say that talking about the tough stuff isn't important to you. I think that's super critical, right? And I like being able to share that with other folks. But also having other examples...a more broad range of experiences that you're going to go through, right? Rather than just, "oh my God, this is all doom and it's hell," and you know...how to live in a more positive way and hearing more stories of guys going through this kind of stuff and living well and treating themselves well.

This participant was seeking stories other than those shared at the group. While he saw value in having a venue for trans men to express their frustrations, he also wanted to hear a broader range of stories from trans men who were doing well and had utilized effective strategies that could be helpful to other group members. The dominance of negative stories in participants' accounts of support groups identifies one of the primary challenges they were encountering. As practitioners who refer people to support groups, we hope that our clients will get positive support rather than 'horror stories', however expressing the difficulties seems to be part of the process. For those sharing their challenges it may be therapeutic, while for those hearing them it may be the impetus they need to seek out different stories.

Problems were not limited to support groups however. During an assessment meeting with healthcare professionals, one participant recounted his interpretation of the troublesome perspective on transition that the psychiatrists shared:

Right from the beginning when I chose to go and see the two shrinks [laughs], they tell you whether or not they think that you are [trans] based on their analysis. I was aware, I'm of colour, right, and here are two people who are white telling me: 'Oh alright, so what's going to happen is you're going to get

all hairy and smell a certain way and you're gonna get really big." And I said to him, 'I'm gonna become a guy. I'm not going to become a white guy.' And I got at that moment that the model in which transitioning was all based was on white. I went, 'Ah okay, this is a whole world that doesn't even relate to me.

So I'm just going to go out and create my own path.'

This participant was conscious that the assessment by the psychiatrist was external to him and that there existed a power differential. At the same time he was aware of his own Other-ness in this situation; he was a person of color and the psychiatrists were white. They did not see differences in the effects of testosterone on people of color that this participant had already considered. He was aware of his own biology and genetic predisposition and recognized that, as an Asian man, he was neither likely to grow substantial facial and body hair nor gain a great amount of size. He would become a man, but not in the image of a white man. It was struggles like this one to overcome a particular hurdle that allowed participants to demonstrate the resilience they needed to proceed with their transition plans.

There was an awareness that participants brought to their early transition where, in some cases, they were able to identify the lack of pragmatic strategies that would be helpful in transition. In other cases participants just knew something was missing and that the stories they were hearing were only focused on what was not working. Their lives were not miserable, and they did not want others at the group to negatively affect their state-of-mind.

Another participant brought an insightful analysis to the utility of the negative and positive stories:

I'm looking for positive stuff but I also acknowledge that there is a history there where we, as a group of [trans] people, have had to rely on those negative stories to get the care that we require.

This participant was aware of the political contexts within and through which trans men have moved and participated in order to access health care. In many cases participants spoke of exaggerating their experiences in an effort to subvert the system and get their needs met. There was recognition of the dependence trans

men have on the health care system and the relationship each person has with that system.

The participants in this study each described themselves as being post-transition, each using a unique subjective assessment. As post-transition trans men, they brought hindsight to their recollection of their experiences in early transition. A common topic participants described was 'passing' or being 'read' as a man in social interactions, which in my experience is a highly charged concept within trans communities due to interpretations of inauthenticity. 'Passing' was explored by participants in a number of ways and contexts. One shared:

I mean some of [my satisfaction] has to do obviously with 'passing,' um, like I mentioned in the group. Like I don't feel this, like, angst every time I leave my house because someone's going to beat the shit out of me 'cause they can't tell what's going on with me.

This participant spoke clearly to the social anxiety among trans men of being perceived as gender variant while in public and how the resulting confusion is for some people sufficient reason to act out violently. In terms of personal well-being, he believed 'passing' helped to lower his anxiety. Others shared similar concerns.

Participants were also aware of differences between transmasculine and transfeminine experiences and that, in terms of passing, those on the transfeminine spectrum often have a much more difficult time. As participants embarked on their transitions and particularly when they began TRT, they had a great deal of anxiety going out into the world with a more gender ambiguous appearance. One stated:

It can be totally exhausting just being you. It can be emotionally overwhelming, um, just walking in society. But since I have a beard I [only] get 'she' occasionally from the bus driver.

As this participant demonstrated, it is in everyday exchanges that non-normative gender presentation can be stressful. This anxiety remains despite knowledge that the masculinizing effects of testosterone replacement therapy (TRT) generally happen more quickly for trans men than trans women – over weeks and months rather than years – and that they would likely not require additional surgeries to 'pass' as long as their breast are of a size that can be concealed. They feared that

an androgynous face and a higher-pitched voice would reveal them as trans and thus they practiced masculine manners of walking and moving. One participant shared:

I didn't pass as quickly as most people I know do. I didn't change my mannerisms a lot. I still talk with my hands a lot and that sort of thing...

There's lots of these little things that in the beginning [other trans men] tell you you have to do to pass.

Additionally, the significance of growing facial hair as an unambiguous marker of masculinity cannot be overstated in terms of subjective well-being; this finding was consistent among the six participants who were able to do so and the two who were not because of genetic or biological factors.

Appearing as a man is only one level of 'passing,' while having supporting documentation of a masculine identity was another important component to participants, although not always easy to access depending on how effectively individuals could 'pass' in social contexts. This challenge is highlighted in this brief dialogue from the second focus group:

Participant 1: My driver's license had expired and I remember going down to the driver's license bureau and, I always got mistaken for being a guy. It's like ever since I was knee high to a grasshopper. I went in and thought, 'I wonder if I can get them to change the gender of my driver's license without proving that I'm a guy.' And so I remember going up to the counter and said, 'Oh, by the way, they made a mistake on my driver's license. They put an 'F' on and I never changed it because it's just, like, a hassle. But now that's it expired, can you...?' She's like, 'Oh my god, I'm so sorry. I'll fix that.' And all of a sudden I had a driver's license.

Participant 2: They didn't want to do that to me. They're, like, 'No, you need to show me another piece of ID.'

The first participant talked about having had a masculine appearance even as a young person and he used this to his advantage in this powerful act of transgression. Later in the discussion he made it clear he was aware of the social investment in a gender binary as he spoke with the agent at the licensing office.

Someone with a gender-neutral name like he had, and who presented so unambiguously as male could only be that sex and therefore the categorization as female on the driver's license must be a clerical error. For the licensing office agent, there was perhaps no space for gender alternatives in that exchange. Also interesting is how the first participant stated at the end that suddenly he had a driver's license when clearly he had had one previously; this was a five-year renewal that required a new photograph and the issue of a new license card. What was different for this participant was that now his driver's license held new meaning and was useful for supporting his affirmed gender in the world. No longer did it have attached to it the low-grade anxiety that might come along with knowing that his gender could be questioned by any police officer pulling him over for speeding or a broken tail light.

The second participant had a different experience when he renewed his driver's license. The clerk was unwilling to change the gender without seeing an additional piece of identification. This participant believed that this was purely a policy-based, bureaucratic decision on behalf of the agent, however, the importance of 'passing' as male socially cannot be ruled out. This participant did not have the same traditional masculine markers as did other participants. While others sported beards and revealed chest hair above their shirts, this participant's youthful, hairless presentation may have raised red flags for the licensing clerk, and perhaps the clerk had other knowledge or experiences that influenced the decision. Regardless, there was a disparity in the experiences that these trans men had depending on how effectively they were able to 'pass' as male in society. Related to this disparity there reside varying levels of social anxiety, which, as previously stated, are connected to concerns for personal safety.

Overall, there were a number of small issues raised by participants in regard to this significant experience they call "transition." From the personal epiphany of recognition, through support group meetings and mental health appointments, to the perceptions of the outside world, these men were challenged and ultimately demonstrated their capacities for self-efficacy.

Positive stories from other trans men offer hope. At the first focus group one participant reflected on the personal impact of meeting a groups of trans men who had a different story to share from what he had heard previously: “I kind of knew, even hearing my first positive story, that there was hope and I was going to get there.” What this quote revealed is that when this participant heard that first story he already had a sense of hope; this story was more of a confirmation. He said, “I kind of knew,” suggesting that this was an ongoing feeling that he had been having. Clearly he had been not just looking for positive stories, but had made a unilateral categorization of previously-heard stories as negative and unhelpful. With the benefit of hindsight from the position of a post-transition trans man, he was able to define that first positive story and use it for comparison to the negative stories he had previously heard from peers in the community and from healthcare providers. The impetus, however, that came from that story was that he could continue on and complete his transition. He might have the same degree of success as was described in that first positive story he had heard.

Numerous accounts shared by participants confirmed that negative stories presented by peers and healthcare providers were pervasive and unhelpful to participants. The negative stories that participants heard described a particular way of going about transition that was fraught with barriers and challenges. On reflection, one of the participants offered this advice: “I just want some positive [stories]. I want people to know that you don’t have to have this script. You don’t have to do it this way to be happy, you know.” This participant referred to a “script” that a person can choose to follow, and thus infers both alternative scripts and the agency of the individual to select among them. He described a prescribed path that trans men are expected to follow and, as I will discuss later, this path privileges the medical experience of transition over the individual one. This participant needed positive stories to counter the negative ones that are so insidious in trans communities. The advice this participant had for others, as much as for his younger self when he was in his transition, was that trans men might find happiness along alternative paths. Another participant also spoke about countering the dominant stories about trans men in transition when he said:

Trans people right now are the sexy topic. And the sexy topic seems to be, you know, they're alcoholics, they're prostitutes, they're drug addicts, they're this, they're that.

This participant was aware of the community-level impact when negative stories about trans people become the “sexy topic”, as well as the broader societal impact of those stories. These stories feed larger narratives about trans men and trans people that perpetuate the ongoing pathologization of these communities.

Participants did not deny the existence of challenges, nor did they deny the merit of hearing about the challenges. What they wanted to be different was to balance the challenges with stories from those who had found their way through them.

There were a few more people, sort of the more senior people in the community. I found that they didn't actually share as much. They'd answer sort of technical questions, you know. “Who's a good doctor for this?” You know, “I need to find a psychologist.” You know, “Is there anything I can do about my acne?” All these sorts of technical, practical questions. They were more than happy to answer that. But I didn't get a lot of, ‘This is my life and this is where it rocks’ kind of stuff from people. And I looked for it.

This quote illustrates that the participant clearly saw a hierarchy within the community. The individuals whom he referred to as “senior people” seemed to be those who had progressed further along in their transitions. He had expectations about what information these individuals would provide and they were not meeting those expectations. He talked about them as responding to more mundane questions but, similarly to participants in this study, these “senior people” in the community were reluctant to talk about what worked well in their lives. What he really wanted to hear was some “This is my life and this is where it rocks” stories. This participant went on to reflect on his awareness of these senior people, their reluctance to share, and talked about his own experience:

I'm overwhelmingly happy with my life, but I certainly am not sharing that with anybody who is beginning off in transition. I don't know. I wish there was a way I could do that.

Here I heard the first hint of guilt from participants, a consistent theme in the focus groups and interviews. Participants identified how content they were in their lives and saw themselves, much like those “senior people”, unwilling to share their positive stories. When this participant said he wished there were a way he could share his stories, it was not for lack of a venue: he knew the whereabouts of the support groups because he had previously attended them. Participants saw value in hearing positive stories in that these were in most cases the impetus for getting on with their own journeys. I often asked participants how they might let their stories be known by other trans men and they commonly responded that they just did not know how, and that they hoped I might be able to do so with this research project.

Personal supports and resources impact the ‘success’ of transition.

Participants in the study identified a number of social supports that were important to them while they transitioned. One spoke about how the eccentricity and numerous challenging issues and personalities within his own family actually lessened the anxiety that he felt from his family.

My family is just really weird. Everyone’s got some odd thing but nobody cares. You know, like nobody really cares. My family is whatever, just be yourself, you know. And that’s a good thing. I think, uh, yeah, that’s a good thing. Like I always think my friends are the “be all end all”. They are so not. It’s my family. It always goes back to my family.

This participant explained during the one-on-one interview that his family situation was quite complicated due to a history of eccentric family dynamics. Ultimately, all of the interpersonal complication raised the bar for this family in terms of what might create tension. Within the context of this particular family, exploration of gender and transitioning was not particularly upsetting.

Personal support came in many other forms. For one participant, support came from a best friend and confidant, someone with whom he attended support groups until they realized that there was nothing there for them but negative stories; in response they formed their own support group of two. Another participant talked about the value of his close relationship with his mother and father. Three other participants spoke about the role strangers had played when they began their

transition experience, be it the voice at the other end of a telephone support line or the individual who answered emails through websites. For another participant it was a trans neighbour who invited this participant into his social circle of trans men and allies who lived in the neighborhood.

In terms of resources, participants spoke of using personal resources like education and knowledge of the healthcare system to navigate through the hoops service providers offered. Participants talked about utilizing the resources and the relationships they had with service providers in order to get what they wanted. By far the greatest resource that these participants accessed was the ability to foreground transition as the primary focus in their lives. One explained:

Within the first two years I'd sort of wrapped up all the medical stuff, which a lot of people can't. In the community, the people that I have been talking to, that has not been true for them. And so, part of the reason I don't want to go to a group and talk about how awesome my life is because I made some decisions and sacrifices and I had some opportunities that some people don't have. I decided that this is, this is it. This is the most important thing to me right now so I'm just going to do it. And, um, I have the financial means to do that. I will be paying it off for the next 15 years but [laughs], I made a financial decision that some people aren't able to make.

At first glance what stood out from this quote was the fact of the participant having the financial resources to be able to afford to not wait for the provincial health insurance plan to pay for the surgery. When the participant said that this was the most important thing in his life at the time he described not only his desire, but also his ability to make transition the focus of his life for that period of time. He was not restricted by other activities or responsibilities in such a way that he could not do this. As he said, he made sacrifices in other parts of his life so that he could focus primarily on his transition. Participants in this study sacrificed jobs, ended relationships, and made space in their lives to focus on transition. They had the capacity to identify a goal and understand the potential barriers and challenges to meeting that goal.

Trans men chart their own course to satisfaction. Participants in this study each found their own way to work with, operate through, and sometimes against, service providers in order to access the health-care that they wanted. Participants were familiar with the *Standards of Care* and either worked with them or around them. Sometimes even their providers bypassed these. One participant had a very fortunate experience with his health-care provider,

I was blessed with a really supportive and accepting doctor. I didn't have to find one. He was already there. He listened to me. I'd ask him for a referral to a doctor in another city and he'd write it ...without question. And we had a discussion about what it is that I was doing and where I wanted to go with it and how fast I wanted to go. That opened up a lot of opportunities for me. I didn't have to stick through some sort of arbitrary system of deadlines and, with the exception of two, healthcare providers that I have dealt with in my entire transition process were really supportive of that. They'd say things like "Sounds like you've really thought about this. Okay let's just do this."

In this case this participant found a physician who was clearly patient-centered and was willing to provide whatever support this participant needed including a referral to a trans specialist in another city who the participant knew would respond more favourably. This was the exception, not the rule, for participants in this study. This participant went on to say that he recognized the difference and that others were sharing very different stories.

Some of the stories I've heard from other people about how they were told they weren't trans enough or that they weren't male enough or that they hadn't waited long enough. As if waiting somehow makes it more valid. That's again part of the reason why I sort of stopped playing in the community, because there were all these stories about that. And I would get so frustrated. "Why are you putting up with that?" You know, "Why don't you just make a decision about what it is that's going to make you happy and what it is that's going to move you forward in your life and do it." Um, which is sort of a decision I came to on my own.

What emerged from this participant's narrative was some recognition of his own frustration at watching others who were not able to pay as much attention their transition and choose transition in the same way that he had. He expected everyone to have the capacity to just make a decision and follow through with it, but in reality that is not actually the case. There are numerous barriers and challenges that individuals confront in trying to follow through with their hopes and dreams. Also we get a sense of why this participant, like many others in this study, stopped participating in the trans community. They shared a degree of frustration with fellow community members, perhaps fueled by guilt, an issue discussed later in this chapter.

This participant had strong opinions about the health-care system, the process that people had to go through, and some of the questions that health-care providers would ask, as is illustrated in this next quote. "I didn't have to go through the bullshit process that lots of people had to go through when they're seeing other surgeons: 'Oh, you're too young. Are you sure you don't want to have kids?'" To answer this hypothetical question, the participant responded emphatically: "Out of my vagina!? No!" and laughed heartily with the other focus group members. This individual, as did others, recognized the gatekeeper status and a particular mentality that many health-care providers have when dealing with trans people. The language and tone used by healthcare professionals has often been patronizing and suggesting that participants would not know what is best for them. Such physicians seemed more interested in preserving the sanctity of reproductive capacity than honoring the subjective gender-based decisions that trans men are making. Participants may not have recognized the ethical responsibilities these professionals have regarding conduct of medical procedures, but accounts like this from participants suggests that their physicians' behaviour and language left participants feeling disrespected and with the need to protect themselves.

Another participant also recognized the challenges of the health-care system for treating trans men. He was concerned for his own mental health and ability to endure that system:

I knew I didn't have the resilience [laughs] to wait as long as some of those other guys. And I wanted to be one of those [more senior guys] so badly. I knew it was going to get pretty bad if I didn't do something. So it was the desire to not want to be on those darn waiting lists.

For this participant it was his understanding of the challenges of maneuvering that system that was in part the impetus for mobilizing himself and increasing his own self-efficacy in order to get his needs met.

Another participant explained having a self-perception that was quite different to other trans people in terms of social locations:

Being queer, not binding, being a gimp, not having a job, not wanting bottom surgery, like all this different kind of stuff. It was just a constant battle. And that story kept coming up. I didn't tell the same story. It just wasn't, I didn't, I haven't always felt like a boy. I didn't always want to be a man. I don't want certain kinds of [surgery]. So the idea of challenging those [negative stories] or –not challenging, that's a bit dramatic, but adding to what those possible stories can be – is sort of what I see this kind of [research project] doing. Like adding, like [transition]'s not all about doom and gloom. There's actually some really amazing stuff that comes out of [transition].

This participant had no lifetime of GID, which went contrary to physicians' expectations and the dominant story about trans people's experiences. This participant self-reported as feeling 'Othered' by trans men in terms of sexuality, presentation, ability, employment and desire for gender reassignment surgery. As with all of the participants in the study, there was an awareness that the dominant model of transition did not match his subjective experience.

In a number of cases participants talked about actually enjoying their transition experience, an idea that is so far away from that negative story. During a focus group, two participants shared an interesting exchange. The first spoke about the journals he had kept for much of his life and, when he went back to look at his entries from the time he began his transition, he saw that he set the specific intent to enjoy his transition experience.

Participant 1: And I felt like some sort of freak for having enj-, I have enjoyed it. I have enjoyed every moment of it. You know, some moments, the post-op pain and that, not so much. Six days of constipation after my hysterectomy, wasn't enjoying that. Oh I had a brutal, brutal time... I was doped up and in pain, puking. But I was always looking at the positive. It was the first time in my entire life – well not entire but pretty much since I was about 12 or 13 – that I wasn't, like, in pain, in that [pelvic] region of my body.

Participant 2: It's amazing the smile you can have on your face when you're puking and you're in the worst pain in your life but it's the happiest moment of your life waking up from surgery.

Through the haze of physical discomfort and pain medication these participants stated they were still able to connect with the joy of the journey they were on. Certainly the first participant was thrilled that he was never going to have menstrual pain again but, more than the embodied experience, his tone suggested to me that another kind of pain was reduced, specifically the one that comes with experiencing a gender-conflicted body process. When an individual experiences himself as a man but continues to have body processes that are inconsistent with his perceived gender, that causes another kind of emotional and, perhaps, psychic pain. One can only imagine what the health-care providers who were observing this participant must have thought seeing smiles and joy in the eyes of someone who was in such a painful physical situation; the contrast of these must have been quite a sight to see.

Part Two: In-depth Studies

Evolving from the four themes just presented, there were three individuals whose stories stood out as examples of some of the broader narratives described in the previous section. In the first, Ed (a pseudonym, as are all participant names in this report) shared the experience of first taking his shirt off post-chest surgery, providing some insight into how he made meaning of his great life. In the second, Kaleb talked about meeting some of those more senior trans men, and the impact these meetings had on his transition. Lastly, Eric spoke of how he used a little plastic egg to help him through a particularly difficult period in his transition. Their stories are examples of, or contrasts to, the narrative themes shared in Part 1.

Ed's Story – “I was like, ‘Yeah, who’s the man!’” When asked, Ed said he identifies as a man, a person who finished his transition eight years ago and thus is no longer trans per se. This was not necessarily the case for other participants in this study but was one way of being that Ed has chosen for himself. When he first contacted me by email he wrote: “I feel as though my life has been hugely successful and satisfying for me. I am very positive and happy to be where I am now.” I chose to write about Ed’s story because his story shared both commonalities and differences with the others in fairly equal measure. In terms of the experiences of trans men I have heard while undertaking this study, Ed’s story seems to be situated in the centre: a typical, middle-class transmasculine experience.

What follows is an account shared by Ed toward the end of his individual interview. In it he recounted the definitive summer story of a guy taking his shirt off in the heat of the day.

I remember the first day I sort of took my shirt off in public. I was out in [a rural area outside of Vancouver] and it was a beautiful hot sunny day. And I was [thinking] “Nobody here knows me.” I’m walking along and it’s just like so hot and I knew I could take my shirt off. I was looking around, thinking about it and feeling a little nervous about it. And I thought, “What the hell?” And I took my shirt off and it was just, like, “Oh my god. This feels so great.” And about five minutes later, this car full of girls drove by and they all started whistling and yelling at me. It was perfect. It was like, “Yeah, who’s the man?!” And I totally had this little ego moment and I felt so excited. It’s like I, I chest-passed, I’ve taken off my shirt. I’ve got scars on my chest and they’re relatively fresh at that point. This car full of girls just drove right past me whistling and waving and screaming at me...I love it. It’s the best thing ever [laughs].

Ed set the scene perfectly: a hot summer’s day, a revealing of the male torso, a car filled with flirtatious ‘hot babes.’ Reminiscent for me of Brad Pitt in *Thelma & Louise* (dir. Ridley Scott, 1991), this was like a teenage boy’s coming of age where he had a desire to be noticed as a man and admired for the body that he had created for himself. In this instance, when Ed marveled that he “chest-passed” it was like a

milestone in his 'trans adolescence.' As much as Ed was comfortable within himself this story revealed through the taking off of his shirt a newfound comfort with his body, an integration of body and self, and a satisfaction of both being accepted as a man and not being exposed as trans. For those who undertake a medical transition with a focus on shifting their bodies to more comfortable alignment with their inner gender awareness, body image and appearance are important early transition issues that can lead to increased subjective well-being.

Immediately at the end of his story Ed connected the shirt-off experience to that of his past and said: "I wish that all women could experience that feeling of just being able to take your shirt off and have it not be a big deal, you know. Yeah, it really shouldn't be, but it is." Here he spoke almost as an advocate when he wished all women could have a similar experience; from his new position as a man he reflected on the benefits that this freedom could have for women within a patriarchal regime that controls women's public attire. This reflects perhaps the sexist and cultural restrictions he resented previously in his female-bodied presentation that he was free of as a trans man. Still, that Ed thought of this as an option, however improbable, was an indicator that he had not forgotten his pre-transition experience when he performed in a female social gender role.

Like a number of participants, gender was something Ed was aware of for most of his life, although the idea of transgender was something that he did not understand until he was in his later twenties. Before this, transgender and transition were not options of which Ed had conceived, or had thought might address some tensions within him. As an abusive relationship with a non-trans woman came to an end – one that caused a six-year rift between Ed and his parents – Ed shared that what became available was the psychic space for him to finally consider transition; until then the relationship had taken up all of that space. His relatively short, two-year transition process included the testosterone-therapy-and-chest-surgery combination that all trans men in this study had chosen for themselves and had successfully accessed; like some others, Ed had also had a hysterectomy.

Having the support of his re-established parental relationship, the stability of a well-paid, unionized blue-collar job, and a comfortable and affordable condo, Ed reflected on his own satisfaction:

I own my own home, um, which is relatively new. Having my mom and my dad in my life and having them be so positive and such a big part of my life now is so fantastic. It makes me incredibly happy. You know, the friends that I have in my life are people that I can have in my life until I die, until they die, whoever goes first. I never really felt that before.

Home, family and friends are staples in anyone's life and key to individuals' sense of stability in their lives. Here Ed spoke with confidence about home ownership and implied the protection that it affords him. He spoke of his parents and friends as playing a significant role in his life today and in the future. And then he said he had never felt this way before about his relationships.

In terms of the personal supports and resources that improved Ed's transition experience, he explained that the stability afforded by family and friends was one important factor in his satisfying life, and there were others.

I have a good job. It's not the greatest job in the world but excitement wise it's kind of dull but it's an excellent job. It's good pay, it's great benefits, it's, you know, it's secure, which right now [in a Recession] I know everybody is freaking out about their jobs and positions and lifestyle. So really, yeah, it's all of those things, um, that are part of my life that make me incredibly happy. Uh, you know, what makes me usually satisfied, comfortable.

Ed's story speaks to the everyday desires that many of us have. Ed spoke about some of his more conventional goals and desires in terms of job, home and social relationships. This yearning for 'normalcy' is consistent with conversations I have had with other post-transition trans men and, to me, it comes across as a 'keeping-up-with-the-Joneses' desire to catch up with male peers in terms of career advancement, family involvement, and social integration. Ed's blue-collar pragmatism shone through in his reflection that his employment represents personal security, particularly in light of current economic uncertainty. He acknowledged the working-

class compromise he made in taking a great job that is also “dull,” and seemed to accept this compromise.

What I would like to highlight here is how conventional are Ed’s desires for family and community and stability. I believe that much of the social construction of the trans experience, at least the non-trans perspective of the trans experience, is that trans people’s lives are significantly different from those of non-trans people. What Ed’s story reveals, and a common thread through the stories shared by participants in this study, is that for the most part these trans lives are quite commonplace.

Ed continued to speak about his current sense of satisfaction:

I like who I am. I like who I’m becoming. Um, and although I’m not, when I say ‘becoming’ actually I’m sort of pretty much there now. You know, physically I very, very slowly change still. And I don’t know at what point changes stop, you know, after you do testosterone for how many years? You know, maybe I’ll eventually get a little hairy chest. I have no idea [laughs]. Right now I’ve got, like, six or seven hairs [laughs].

Ed acknowledged that his transition was not a discrete process; while he was “pretty much there,” small shifts were continuing to occur that may have had to do with ongoing and regular use of testosterone, and/or the relationship of this to aging. Here, also, Ed’s ‘trans-adolescence’ emerged as he wished for more chest hair, a common masculine gender marker. His tone conveyed a lack of stress about this that was likely related to the previous story where he was convinced by the reactions of a carload of girls that his chest does, in fact, ‘pass.’

What seemed to surprise Ed was what he heard and did not hear at the focus group he attended. At his individual interview, he elaborated on his thoughts about life satisfaction, and his perspective on the others who took part in his focus group a week earlier:

Listening to the other people talking about some of their past and where they had been and how people have related to them and where they are at present, I guess it may not necessarily be fair for me to say but I actually didn’t really get a really great sense that some of the people were satisfied

with their life at this point... Satisfaction with your life is all relative to how your life has been, right? And but I just sort of, I expected to feel more satisfaction coming from the individuals because from your original [recruitment] email, you were looking for people who were really satisfied with their lives the way they turned out and stuff. And it just, I just didn't get that from everyone. Interesting here was Ed's need to quantify satisfaction; he thought that participants who would participate in a study like this would clearly be more satisfied than he observed. At the same time he revealed some of his criteria for gauging satisfaction when he said that it is "all relative." Apparently what he heard at the focus group did not provide enough information for him to see how far the other participants had come in their own journeys; while they spoke of their milestones, there was seemingly not enough information about the length of their journey. This highlights for me the highly personal nature of 'subjective well-being' and our desire to compare ourselves to others and, in some cases, disbelieve and deny others their self-proclaimed contentment.

For Ed, his satisfaction was based on the ease with which he has been able to proceed through his transition and the final results. In discussing this with me, he seemed to develop some insights into why others' experiences of contentment may be different:

I feel for myself that the way everything has come together for me, uh, has been hugely satisfying. I feel very lucky because I feel like it's been incredibly easy for me and I know it hasn't been that way for many people. Perhaps that's part of the lack of satisfaction I hear or that I'm picking up.

I am curious about how Ed attempted to come to terms with and understand his own "easy" course through transition as compared to the more challenging experiences of others. For Ed, how much did this ease contribute to his satisfaction, and did he perceive a more difficult transition as being less satisfying?

He was not so sure that the difficulties experienced by other trans people, or queer people for that matter, was all that different from that which non-trans and non-queer folks experience:

If you're talking about stress, I just... you know, people that think LGBT, all those letters together...[and that] we have a harder time, [and] maybe some of us do. But then there's some straight people out there, an awful lot of them that are having equally hard times and harder times. Personally I think really the stress that we as individuals feel regardless of what gender preferences we prefer or what gender we are or are becoming, I find for myself that it takes a lot to stress me out. I don't get stressed out about much. I don't get upset about much. In fact, if nothing else, I think that initially when I started taking testosterone, it calmed me down.

Interesting here is the connection Ed drew to the initiation of TRT. Like two other participants, he spoke of it as calming; another participant said starting testosterone made him feel "more natural." There was no consensus on this particular topic as other participants spoke of testosterone's energizing, sexually-arousing and sometimes emotionally-agitating effects. I do believe that Ed's story raises questions about the effects of testosterone because it is contrary to general thought, questions that would benefit from greater research.

Ed seemed to vacillate between a belief that queer and trans people have a "harder time" and his perception that everyone can experience difficulties in their lives. He saw stress as an important factor, perhaps more important than gender and sexuality. I am reminded here about the impacts of stigma and wonder if Ed, like academics and others before him, was struggling to understand the impacts of the varying levels of stigma on people's lives.

More recently, Ed was looking for a primary relationship. Although he has been in relationships exclusively with non-trans women until now, he said he is now more focused on the individual, regardless of gender.

I don't think it has anything to do with transitioning per se, but I think I've sort of gotten to a point where it doesn't really matter to me anymore if I meet somebody, whoever that somebody is, regardless of their gender. If I connect with that person then, then I'll see where it goes.

Ed seemed to be saying two things: first, that it does not matter if he starts another relationship and, second, that the gender of that person is less important than other

factors. As our interview continued he clearly contradicted the first point: he does indeed want a relationship. What seemed to be more important was that Ed is coming to terms with how his experience of gender may interplay with the gender of a future partner. Ed is also understandably wary about engaging in a relationship due to bad relationship experiences in the past, but his life might be better, more satisfying, were he in relationship..

My other impression of Ed's statement, based on my experiences with gay men, was that this was a 'coming out' of sorts for Ed. The softened, vulnerable tone of his voice as he spoke of the possibility of being in relationship with a gay man reminded me of many conversations with friends and clients as they explored their own sexual identity. Here I believe it was my own identity as a gay man that contributed to, and allowed space and safety for, this sharing of information. "Who's the man?" Ed thought after a rousing chorus of flirts from a carload of girls. I wondered how Ed's constructions of 'man' and masculinity might be complicated by the possibility of accepting a gay or queer identity, and if his tentativeness was in part a reflection of that recognition.

But there remained an issue he was working to overcome:

I lack sexual confidence, you know. As long as I'm fully dressed, I feel great [laughs]. If I'm wearing my [underwear], I still feel fine but...it's just...knowing, removing that last piece and missing [a penis]. I guess, is important, you know [pause]. A lot of guys manage to work through it. I'm still working through that.

Where Ed would at another point in the interview express self-assurance in taking off his shirt after his encounter with the young women, here he expressed a lack of confidence at not having a penis, a primary marker of masculinity and of being a man.

Ed has clearly identified for himself an issue that is inhibiting his experience of intimacy. His experience was that other trans men have come to terms with this and he sees the need to grow in that direction. Implicit in this is also the need for trans men to manage information and disclosure of their trans-ness.

Other participants spoke of similar issues related to body image and sexual confidence and found themselves in different places along the continuum of comfort with themselves. For one participant this was related to a self-described food addiction, another to disclosure of being trans to prospective sexual partners. Eric, who I will introduce later in this chapter, spoke clearly about a shift from being apologetic about his body toward a more matter-of-fact disclosure in the interest of not wanting to waste a potential lover's or his own time. Ed explained that some of the confidence he is lacking can be attributed to the previously described abusive relationship, an experience he clearly did not want to repeat.

In terms of his past, Ed spoke of embracing and integrating the person he was prior to his transition:

And I don't ever want to turn my back on who I was. I think that's a very, very important part of just being able to [pause] to survive happily. It's a huge part of my life that I'm satisfied with that. If I wasn't this person growing up, I wouldn't be this person that I am right now. I know there's guys out there that they don't acknowledge their history. And they don't seem to be happy either because they're always trying to hide something and it's just like there's nothing. Just be who you are and be comfortable with it. Accept what you've got. We do things [like TRT and surgery] to change, try and make ourselves a little bit more comfortable in our bodies. I look at that as being a slightly different thing.

Significant here, in my opinion, was Ed's perspective on medical procedures as they relate to the person he was. He spoke about his chest surgery, and later his hysterectomy and oophorectomy as a means of making the experience of his body more comfortable. For Ed, being more comfortable with his body seemed to be, in part, about revealing himself in different situations, like he did in a rural area outside of Vancouver, and experiencing the acceptance of his new identity. This story suggests the importance of integrating prior life and experience in order to improve well-being and, for friends, allies and other trans people, a red flag is raised for those trans men who might want to deny their prior experiences.

Ed's story demonstrated to me that some trans men do indeed have a positive transition experience that contributes to a satisfied life post-transition. The story he shared about being seen by the young women in the car demonstrated the importance of embodying the transition experience as a subjective, rather than medical, journey. He spoke of the significant support he received from family and friends, the meaning of having stability in housing and employment, and that, all in all, the issues he faced and values he expressed are rather conventional. Ed charted for himself a rather conventional course and found himself a satisfying life.

In the next story, I will describe how another participant came to recognize that there were two different stories about what transition was supposed to be like and how, through meeting a particular group of post-transition trans men, found the incentive to shift how he proceeded through his own transition.

Kaleb – The “Guys in the Woodwork”. Kaleb, a mid-thirties trans man, described himself as being eight years post-transition. He worked in a helping profession and stated at first contact how thrilled he was that a School of Social Work was conducting this kind of “positive research.” Kaleb was the first but not the only study participant to describe a group of trans men who are no longer associated with trans communities and hold a particular kind of transition story. Until he met these men Kaleb felt frustrated with the negative stories he was hearing about transition equally from trans peers and service providers. After hearing positive stories Kaleb became hopeful for the first time, his transition experience made a significant shift and, as he explained, the process began working out much better for him.

I finally found a couple of guys who actually came out of the woodwork to talk to me. And that was when I got to hear the positive stories, the hopeful stories. And once I got to hear their journeys, that was when I started to feel positive. And once I started to feel positive, then things started rolling. Significant in this quote was that Kaleb said that he “started to feel positive” as this was indicative of a shift towards a better mental health. He went on to say that it was with this shift of feeling and state of mind that the activities of transition started falling into place. Again this points to the importance of maintaining a positive outlook on

the transition experience and that the challenge of doing so is directly related to the dominant, negative narrative that trans men endure and that some trans men also perpetuate. Where were these “men in the woodwork” with their positive stories when Kaleb first began his transition? Clearly Kaleb did not hear these trans men’s voices when he first began his journey, but eventually he overcame this obstacle.

Kaleb was able to name and describe most clearly what he called the “negative transition story,” one to which almost every participant referred, a narrative that is portrayed in the support groups and by the medical establishments as the path every trans man should expect to be his own:

When I came out and started, I was told [by peers], “No one is going to approve you. We’ve been trying for years so don’t get your hopes up about getting any [testosterone] or surgery here...” The message that I got early on was just, “You’re going to be unhappy. You’re going to be stuck in a middle place because if they approve anything, it will only be half. So you’ll be stuck in the middle, if you’re lucky to even get that far, or you won’t get anything.”

This story was so vivid as Kaleb described it. The tone of his voice sounded disappointed and the sense I had was that he had hoped for more optimism, encouragement and support. Instead of hearing what the possibilities were, he heard about the limitations. What was missing for Kaleb, something that he did not know but seemed to sense, was that there was another perspective on how to proceed through transition in a much more positive way. Perhaps the conflict was with his state of mind: Kaleb seemed to be the kind of person who sets goals and follows through, so he was responding to the information, as well as the perspective of the individuals who were sharing it; he had just as much difficulty accepting the facts as he did their worldview. Had they spoken of challenges, possible solutions and exceptions to these outcomes he might have responded differently.

Kaleb clarified that the so-called ‘middle place’ he mentioned above was one where a trans person might be approved for hormones, but end up on a seemingly eternal waiting list for surgeries. But this was just the medical component; there were further repercussions based on the input from other trans people:

[They said:] “No one is going to want to date you at all, especially if you’re into

men. Gay men will not want to date you so don't ever expect on dating or sleeping with a gay man" – which is bullshit. Sorry, excuse my language but it's absolute bullshit that gay men don't date and sleep with trans guys. But this is what I was told. So I had this vision of my life as being alone, miserable, depressed in a physical state that I didn't want to be in and just very unhappy. And, and I was going to be ridiculed.

After being told that he would not be able to access the health care that he desired, Kaleb was informed that he would also be socially isolated. Kaleb was angry. There was a shift in his tone and his use of the word 'bullshit' revealed his growing frustration at the time as well as his hindsight perspective. As he recalled his experiences, his affect suggested that he was counseling an earlier version of him, sending a message to himself at that time that there were other options, and that the messages he received really were "bullshit."

As though the medical and social ramifications were not enough for Kaleb to contend with, he was also forewarned about the perceptions of employers in terms of mental health and substance abuse.

Oh, "You're going to lose your job." I heard from medical professionals and the community that, "No trans guy can successfully transition at work." Yeah and, "All trans guys have mental health and [alcohol and drug problems]." [pause] I heard all these things and I'm finding that none of them are applicable to my life now.

Kaleb described more of these allegedly definitive outcomes, the unavoidable experiences that every trans man must endure. Kaleb expressed his frustration at hearing no alternatives to unsuccessful transition, only blanket statements purporting a predestined outcome. From a place of hindsight, he stated that these issues were not, and have not been, for him, significant during or post-transition. For Kaleb, this list of outcomes that the "negative transition story" predicted instead became a survey of experiences that he avoided and, in part, I expect some of his motivation through transition came from a desire to prove that story wrong. He would proceed through transition differently.

So who were these people from whom Kaleb eventually heard a different

transition narrative? Kaleb introduced the idea of the 'guys in the woodwork.' I asked him to clarify who they were and their significance:

After about six or eight months I got wind that, that there were the 'guys in the woodwork.' That's what I ended up calling them – 'the guys in the woodwork' – because they certainly weren't at any trans event or social or support group. So, I made it my mission to find them 'cause I thought, "these guys are my answer." I actually found these 'guys in the woodwork.' And these were guys who transitioned five, ten, fifteen, twenty years ago and are very happy and content in their lives and got through their transitions despite what the professionals will sometimes tell you, or guys in the community will sometimes tell you. It is possible to move through the process in a good timely manner with lots of support.

At this point in the interview Kaleb clarified that for the first six or eight months after his decision to transition he actually believed the "negative transition story." There was optimism in his tone when he spoke about discovering that there was another story and it became the focus of his transition from that point forward. What I learned was that, contrary to the dominant assumption that transition must be situated within a medical and health context, Kaleb stated clearly that a phase of his transition consisted of seeking out trans men with positive stories so that he could make different choices about how he would engage in his own transition.

Kaleb spent the first six to eight months of his transition searching for answers because it was clear to him that stories he was hearing were not quite right. The messages he was getting from the community were not consistent with his worldview and it was only when he met the 'men in the woodwork' that he finally heard some positive stories. His experience put the subjective experience of the transition journey in the foreground. This differs from health literature and popular discourse about transition that focuses on medical and psychiatric aspects of transition. In terms of mental health, a positive outlook can have a significant effect on the experience and success that trans men will have. Kaleb was not the only participant to highlight the merits of a positive outlook on life in relation to a successful transition. This suggests that not only can the "negative transition story"

be a barrier, but also that an optimistic approach to transition can improve the mental health outcomes and sense of satisfaction for trans men.

Kaleb stated that once he sensed an internal shift from a negative to a positive attitude that was when he recognized he was in control of his transition and became assertive about starting the medical components of it. “I got on testosterone, I got my surgeries – with a lot of guilt mind you... [laughter] ‘cause guys that lived here five, you know eight years before me were still on waitlists for surgeries.” Kaleb’s reference to guilt combined with the laughter that followed expressed the degree of his discomfort in knowing that he had managed to get his needs met while others were still struggling to do the same. Kaleb understood that he had socio-economic advantages that made accessing surgeries easier for him, and he was only one of many participants to describe the guilt that interfered with these post-transition trans men’s present-day participation in trans communities. They speak of the negative stories they hear at the groups and yet by not returning with positive stories they perpetuate exactly what they found problematic. They spoke of their desire to be involved, and then an inability to do so. Later, I will report on another participant, Eric, who described more broadly the experience of guilt and its ramifications. I believe the reason many of these trans men no longer associated with trans men communities was in part due to a perspective that they had completed their transitions and that they were no longer seen as trans. Perhaps they saw trans communities as people sharing the sole interest of transition and simply found little use for these groups anymore. Or perhaps they preferred to move away from situations that reminded them of the ease with which they transitioned, while others continued to struggle.

Based on information Kaleb gleaned from these ‘guys in the woodwork’, he recognized that there was a game that he needed to play in order to get the health care he wanted:

At the gender clinic...they expected me to be depressed. And I went in there not depressed [laughter]. But I kind of got the message from some of ‘the guys in the woodwork’ [that] you have to play the suicide game. And I wasn’t suicidal but I had to pretend I was a five [out of ten] on the suicide scale. [I

thought], “Oh I’m going to have to hone my inner acting abilities from high school” because if you weren’t, then they weren’t going to approve you for anything... I had to play the suicide game and I thought, “This is ridiculous. This is so bad that I have to pretend that I’m this suicidal to get you to say yes to something.” I had all the guys tell me, “Oh, your doctor is not going to say yes.”...It’s crazy how many people expect you to be that depressed and suicidal whether it’s the peer support from the community, whether it’s psychiatrists from the old gender clinic. It’s crazy how depressed you have to be to prove that you’re trans, that you’re really a four or five on our trans bullshit scale.

This powerful narrative reveals how Kaleb and the Woodworkers colluded to undermine the systemic barriers they faced and take control of their healthcare through an act of resistance. In a way they had developed a variation on the script by which the healthcare providers were expecting them to play. Without a doubt, any mention of a “suicide game” can be dangerous. Kaleb and the others would not be expected to understand the responsibilities a social worker would have to support the positive mental health and well being of their clients, particularly those who may be exhibiting signs of suicide. They have no need to consider the legal and ethical responsibilities and balance these with the right to self-determination of clients while considering clients’ capacity to make decisions for themselves. To introduce an additional factor, a game where clients are ‘acting out’ suicidal ideation is unnecessary; clients should be able to speak openly about their mental health. Kaleb was not the only participant to describe how he influenced his health care. Another participant spoke of web sites accessible only to trans men which list service providers and wherein trans community members recommend language, behavior, style of dress and affect that they believed that these providers were seeking and what they thought might lead these providers to deny trans men the services that they sought. These are the kinds of obstacles that the men of this study felt that they had to conquer.

Kaleb’s story revealed the magnitude of the “negative transition story” and the multiple realms on which it can have an impact: social supports, relationships,

housing and employment are all potentially at jeopardy, but this is not a foregone conclusion. It was in response to the many manifestations of the “negative transition story” that he demonstrated the resilience and coping strategies he needed to persevere with his decision. In the next story I illustrate some of the impacts that the “negative transition story” can have on one individual’s mental health and wellness. As we will see, in Eric's case it presented a significant barrier and added complexity to maintaining his mental health as well as his sobriety.

Eric’s Story – The bright orange egg. Eric first contacted me to participate in the study and stated clearly that he would not have taken part, or even opened the email describing the study, had it not been for the direct recommendation of a third-party recruiter, another trans man, who vouched for me as an ally. Like all participants in the study, he described a rather quick progression of less than two years from his decision to transition to completing the process. For him, this involved TRT, chest contouring, hysterectomy and oophorectomy.

A former substance abuser with four years of sobriety prior to starting transition, Eric reported that every day for the first year of his gender transition he carried a small orange plastic egg (such as those found in *Kinder Surprise* chocolate treats). Inside, rather than a toy or puzzle, it contained a mix of illicit drugs. One might immediately think this was a foolish idea on his part; indeed, even Eric questioned the merits of that decision. He quite deliberately and thoughtfully described how he came to carry the drugs with him:

It was hard in the beginning not to, [pause] not to go back to using drugs... At one point early in my transition I was so close to using drugs again. I started actually carrying them around with me. I’m not sure what part of my brain thought that was a good idea, but I sort of had this idea that one day very soon I was definitely going to need to do it. And I didn’t want to have to, like, freak out ‘cause I didn’t have any access [laughs] to drugs.

In retrospect, Eric questioned the cognitive process that brought him to purchasing crystal methamphetamine, ecstasy and some unidentified prescription medications, and carrying these around with him in a bright orange egg. He told me that every evening he would empty his pockets, including the egg, and every morning tuck the

egg back in. Particularly in the beginning weeks and months of his transition, he felt that returning to substance abuse was not just a possibility, but a certainty. He described his relationship to substance use in terms of spatial and temporal proximity; he was “so close”, and at times he spoke of the immediacy in terms of hours. Despite a four-year abstinence, as he began transition he said the balance his life, career and relationships family members still felt “precarious”; to transition might risk upsetting this tenuous balance further. Substances had been a way he had coped with these in the past.

Eric never did open the egg. “One day I was like, ‘this is a really fuckin’ bad idea’ [*laughs*]. And that was that! I got rid of them and that was that.” Eric had been so certain he was “definitely going to need” the drugs to help manage anxiety, so what happened? There was no grand drama, as he had expected. He had managed to prevail over the difficulties he had faced early in his transition. The drugs had been available to help him cope with the transition-related challenges that he had been convinced would arise. A year later, when these challenges had not materialized and he was feeling more satisfied with his life, he simply disposed of the egg. “I didn’t think I was ever going to tell [that story to] anybody. It’s interesting.”

Eric’s successful negotiation of the health care system did not come without its challenges, as he explained:

Everything happened very quickly and I felt guilty about that. And I sort of still do because I didn’t spend a lot of time really talking with other trans people about their transitions. I did a fair amount of listening, and then...all of these people, so many people couldn’t get testosterone or couldn’t actually take it for some medical or whatever reason. It’s sort of the medical path; usually the first step is testosterone. And so many people were having trouble with [accessing testosterone], not to mention the hysterectomy, the chest surgeries and the lower surgeries, and how long people were waiting. And I think that, to be honest, it’s like a big part of why I disengaged from everything. And, I know lots of people who are four, five, six, seven years or more who still haven’t had surgery. So I guess... [*pause*] There’s guilt that I deal with that I think I’m always going to. And I think [that guilt is] always

going to prevent me from sharing to some degree. I mean it might just, um, my story is sort of, I tell it differently depending on who's listening. [*looks at recording device*] Um, but I'm trying really hard not to think about who's listening right now [*laughs*]. It's just you.

The guilt Eric described, much like Kaleb, is in response to the “negative transition story,” within which he saw others trapped while he was able to progress. In Eric's case, he paid for some of the surgeries out of his own pocket. He had the resources to ensure his transition would be successful. Eric's discomfort seemed in part to be situated in the awareness of his own economic and class-based privilege. One could argue that even with the challenges of trans-phobia, he experienced easier access to healthcare services because he was white, college-educated, possessed strong English language skills and had the financial resources to pay for service. The same could be said for most of the trans men in this study, although having class-based privilege does not necessarily removed systemic barriers as much as it reduces them.

Eric was aware of his social location within the discourse about transition, and the “negative transition story” in particular. He saw himself in relation to that story and at the same time separated from trans men's communities by the fact that his own story did not match the negative narrative. The institutional structure of the health care system, by limiting access to transition-related services, perpetuated the isolation and contributed to the misery of those other trans men, those still waiting “four, five, six, seven years or more” for services. Eric saw me as a researcher and ally in another, separate role; while speaking to a queer man, he was more at ease and less inhibited by guilt and made efforts to not censor his story despite his aware of the recording device on the desk between us.

Eric acknowledged that his success came in part due to his sobriety at the time he began his transition. Four years prior he had stopped using a mix of prescription and recreational drugs when he realized the negative impact they were having on his life. He quit ‘cold turkey.’ On reflection he stated:

The idea of transitioning in the middle of all that... [*pause*] would not have been helpful. I likely would have not ended up clean or transitioning [*laughs*].

It would have been some sort of nasty death spiral [*laughs*]. Um, fortunately I deal...I dealt with my substance issues a lot, like several years before I started transitioning.

Interesting here was the slip in language (one I would have missed were it not for my astute transcriber). He clearly spoke in the present tense when he said, “fortunately I deal”, and then shifted into the past tense and restated the word as “dealt.” While perhaps not in the forefront of his current life, I interpreted this to mean that he maintained some conscious awareness that his substance abuse was to some degree an ongoing issue. In terms of the realms of his life that Eric reviewed in assessing his subjective well-being, clearly his sobriety was among them. Furthermore, in retrospect, Eric was aware of the ramifications had he misused substances while in transition: probably neither sobriety nor transition would have been successfully achieved.

Like many might, I was believed in the inadvisability of carrying the egg until my advisor asked if there was another way I might understand it. Indeed, had the egg been empty, I could imagine it as a talisman that offered comfort to someone who felt quite alone on his journey toward finding himself. He navigated his own path and took along with him a talisman for protection and, while he appreciated the security of having it, he neither opened it, nor consumed its contents. So what difference would it make what was inside? By carrying around this egg, Eric put himself at risk for legal troubles and relapse, but at the end of that journey he was just fine. Eric made choices, some wise, others perhaps inadvisable, but whatever the combination, he eventually reached a place of contentment some years ago.

Eric, like Kaleb and other participants in the study, credited some of his success to having heard positive transition stories from post-transition trans men. These ‘stories from the woodwork’ were the exception, and not easy to come by as the individuals sharing them were difficult to locate. After finally hearing these stories, Eric and a close friend decided they would stop attending a popular peer support group in order to dislodge themselves from the downbeat stories, and to make their own path.

Eric's story demonstrated not just his ability to cope with the pressure of the "negative transition story," pressure that was magnified by a history of problematic substance use, but also how misinforming that story can be. How much did that pressure impact his decision to pay for his own surgeries and bypass the system of transition, and many of his peers within it, just to avoid the added burden of that route? What might be different if perspectives on the medical transition shifted and were more in line with Eric's personal intention; would it be possible to conceive of TRT and surgeries as enjoyable, positive experiences for those who choose them. While I would expect most trans men might be contented to undergo medical procedures because they are eager for the results, can enjoyment be found in the journey as well as the destination?

Chapter Summary

The themes I have presented are broad, reaching across this group of participants, while the stories I have shared are as unique as the individuals they represent and speak to a subgroup of trans men who have made particular choices around how they would proceed with their transitions, choices many others make differently. These stories are neither intended to demonstrate how all trans men undertake transition, nor provide evidence for how trans men *should* do this. Instead, I have used selected stories from my conversations with trans men to illuminate some of the key ideas I take from this research project. I elaborate on these further in the next chapter.

There are two competing narratives about transition that the trans men in this study shared about their mental health and wellness. In the first, as Ed and the other participants demonstrated, much like the 'men in the woodwork'" before them, many trans men have satisfying, perhaps even conventional lives. They found satisfaction after prevailing over the challenges of early transition and despite the louder rival narrative in the "negative transition story" that Kaleb and others so effectively described, wherein trans men are pathologized unwitting victims at the mercy of healthcare professionals and society, destined to live miserable lives. The potential impacts of this latter narrative are immense, and speak to the strength and self-efficacy of those who do successfully maneuver through their individual transition

process, however they charted their own course. In this study we read about participants' bold, transgressive acts that undermined the systemic barriers they faced and subverted the dominant medical narrative. Supports and resources made constructive contributions to these participants' lives, and although partners and families were key for some, for others it was the kindness of strangers that made a difference. Having access to class-based resources such as money, education and language made a key difference for some participants. Ultimately it seems vital that trans men who complete their transitions share their stories in order to give hope to other trans men, however participants and the 'men in the woodwork' are reluctant to do so.

Participants in this study assessed their life satisfaction in many common ways. They valued maintaining social relationships and having stable employment and housing. More challenging for individuals in the study were the negative social forces, particularly those implicated in the "negative transition story," and how these exacerbated anxiety for those who did not have strong coping strategies. For those with a history of problematic substance use, maintaining sobriety was a significant consideration. While participants noted that their transition experiences had contributed to improved mental health and wellness, they were reluctant to speak about their experiences with others who were still transitioning despite knowing the benefits of sharing positive stories. In the next chapter I discuss possible reasons for their reluctance. I also consider the ramifications of these findings more broadly within the context of the present literature, both scientific and theoretical, and discuss how these could inform social work practice and future research in this area.

5 DISCUSSION

Funny, heart-warming, difficult and curious were the stories I heard in March and April 2009 when I met eight generally-satisfied trans men from Vancouver and asked them to describe their journeys. We gathered in small groups at the offices of a local non-profit, and then I visited with each one-on-one, usually in their own homes. I heard about what made their lives so contented in the present, and their reflections on the challenges they had faced and managed. The findings demonstrate the complexity and contradictions experienced in these lives, and are not simply black and white narratives. With these stories in mind, I discuss here my interpretation of the issues.

As a reminder, my primary research question asked: what can be learned from the stories of trans men about their mental health and wellness? In relation to this, I was curious in which realms of trans men's lives is satisfaction important and/or significant? I answer these research questions within three thematic areas. First I underscore the reality of participants' contentment with their own lives, and the realms of life they considered in their self-assessment of life satisfaction. Next I describe the impacts of the "negative transition story" on the lives of participants. Finally, I explore how the tension between these two narratives resulted in these trans men becoming so alienated from their communities. Then I move on to discuss the significance of the research findings within the context of the present literature on subjective well-being and quality of life, and theories of identity development. I discuss implications for strengths-based social work practice and introduce an assessment tool that I created for mental health and addictions counsellors to explore with trans men some of their transition-related issues. Finally, I reflect on my methodological process and make suggestions for future research.

What was Learned about the Lives of Trans Men

The road to satisfaction. Participants described a number of factors that contributed to their life satisfaction, some rather commonplace, others more unique. Like many, having access to healthcare, resources and social supports made a difference in being able to ease through transition. For those with a history of problematic substance use, ongoing sobriety was key. As trans men, the desire for

friendship with other trans men, and partnership was important. They recognized the benefit of overcoming intimacy and body-image issues and reaching greater comfort with their own bodies. Integration of pre- and post-transition selves was a significant issue for these trans men.

Participants in the study demonstrated that it is indeed possible to be a contented and happy trans man, although each individual described this experience uniquely. In three cases participants set as an intent quite early on that they would undertake their transitions differently, perhaps enjoyably. In four cases, they spent the first six to eight months seeking out a different way to go about transition because their experiences did not match the negative stories of others. Most participants eventually found 'men in the woodwork' from whom they finally heard some positive stories. Participants wanted to hear from others who had found their way through the healthcare system. They sought stories that might help them find the intrinsic motivation and ways to proceed with transition on their own terms. These stories highlighted the personal part of the transition journey, a divergence from the healthcare literature and the popular discourse about transition that focuses on the medical and the psychiatric experience.

The participants in this study each demonstrated a degree of personal dedication in deciding to go about their transitions in their own way. They each shifted their transition into a personally controlled experience rather than relying on a medically-prescribed performance of transition. They challenged the implicit bias in stories that suggest 'completing' transition as an idealized experience that necessitates all trans men undergo TRT and have both top and bottom surgeries. This bias demeans those who do not choose that path by making them lesser trans persons and encumbers them with expectations regarding the hormonal and surgical steps they should take; further it ignores that some trans men may feel quite content solely with TRT and, being comfortable with their bodies as they are, have no need for surgery. Legal status and documents notwithstanding, newly transitioning trans men need to know that any point on the transition spectrum can be an end-point and is perfectly valid and legitimate. Further, they can choose to stay or move along the spectrum at their own pace if they have the resources to afford the time and surgery

costs. Ultimately the participants in this study were able to take control of their own lives and decision-making, and demonstrate self-efficacy in their negotiations of the medical system.

The “negative transition story.” This storyline, as told by participants, suggests that being trans means having had life-long gender identity disorder, and mental health and addiction issues. Individuals will lose their social supports, housing, and employment, and find accessing healthcare, including transition, daunting if not impossible. This story, perpetuated by trans and non-trans people, peers and providers alike, is so convincing that some participants resorted to extreme measures in order to manage their anxiety when pre-existing coping strategies were limited. The potential impacts on mental health and wellness in trans men’s communities include significantly increased anxiety and stress.

The challenges participants faced when accessing health care, while real and substantial, were a symptom of a greater systemic problem, and they recognized they could change that story. Rather than accepting this narrative as the only outcome for their experience, the participants in this study resisted and chose a different path. Study participants demonstrated a greater sense of contentment when asked about life satisfaction, and were able to consider medical gender transition among a larger list of options.

At its core the message of the “negative transition story” seems to be that transition will lead to misery; further, the primary purpose of the “negative transition story” is to maintain the problematic gender binary: There are only two ‘natural’ genders – natal men and women – and life satisfaction can only be experienced from either of these two biocentric poles. Any degree of variance from these positions brings with it an associated and appropriate level of stigma, discontent and misery. Further, even those trans men whose transitions achieve convincing masculine appearances could never be content because they have undermined the essential sex to which they were assigned at birth. This story highlights the investment that some members of trans communities have in maintaining this narrative, and their perception of health-care providers’ similar participation.

Two narratives converge. A peculiar dichotomy exists in the experience of post-transition trans men and their relationships to trans communities. Participants spoke of the significance of hearing positive transitions stories and yet found these stories hard to come by. Participants spoke about frustration and guilt when considering their own experiences compared to other trans men they knew. Participants met the ‘guys in the woodwork’ and then became them. Like those men, participants had distanced themselves from trans communities. They spoke of guilt associated with their perceived ease and facility at completing transition and their moving on to a satisfied life while others have been unable to do so.

I believe that this guilt stemmed from an awareness, overt or not, of the numerous social disparities that prevent equal access to and experience of gender transition. For example, being of a lower class and living in a less affluent socio-economic situation could prevent access to trans-related health care simply for financial reasons, even if partially subsidized by medical insurance. When I asked what participants could do to help disseminate positive stories, they said they were willing to tell their stories, but only if asked.

‘Transgender readability privilege’ (TRP) is the language I created to describe the confluence of factors like race, class, biological and genetic predispositions that make social interactions easier for some than others within a Western society because others perceive them more easily as the affirmed gender. Here I use the word ‘read’ as an interpretation that may or not be the intent of the individual in question. There are many influencing factors and I highlight only a few here. For example, being white, being of a particular class that a person can afford to transition, and/or also having the physiology and genetic makeup that allows for TRT to work effectively so that facial hair and other more obvious markers of masculinity help individuals to be recognized as men. Race and ethnicity create additional barriers to healthcare for men of colour, particularly those of Black, Asian and First Nations ethnicity described herein, and in terms of how the markers of masculinity are racialized as white and set differently for these trans men. Class-based implications include the affordability of TRT and surgical costs as well as the time and ability to focus transition over other areas of life. The ‘right’ genetics and

physiology combine with TRT can create a more convincing appearance of masculinity. TRP means people masculinize more quickly, and more effectively, because they have greater capacity to maneuver through the health care system and overcome trans-related barriers.

The positive experiences these trans men had during transition collided with the “negative transition story” and contributed to them moving away from trans communities. As they observed others caught up in that narrative, just as they themselves had been at one time, they could not figure out how to talk about a different way through transition. Participants knew how helpful hearing positive stories were in their own experience, yet could not find ways to pass them on. Guilt and privilege seem implicated here, and yet these are issues that a community should be able to manage with extant resources. Their participation in a research study like this one demonstrates willingness and a desire to change the dominant story, however strategies are needed that these trans men can employ.

I highlight this issue of guilt not to admonish these trans men, but rather to underscore the disparity between these men and the vast majority of others. These participants were a rarity in that, for the most part, they had all undergone ‘top surgery’ and some form of ‘bottom’ surgery and had a high degree of socio-economic privilege; they succeeded because they could afford the investment of time, energy and resources to get it done. I do not to deny them their accomplishments because they still had to overcome the systemic and social barriers all trans men face when they transition; this is a demonstration of their self-efficacy. Still, most trans men in British Columbia do not have the resources or social capital to achieve this stage if they desire it.

In order to effect change in the lives of trans men, policy must make it easier to navigate the institutionalized gender transition systems. On a community level this means ensuring support programs and groups such as those described by participants are facilitated in such a way as to counter the “negative transition story.” This does not mean that only positive accounts should be shared, but rather that challenges described by individuals are met with recommendations of strategies to overcome these, and culturally-competent professional intervention when necessary.

Indeed, by investing more resources into transgender healthcare and mental health care that make access easier, we can reduce the harmful impacts of systemic traumatization that may result in extended engagement in a medicalized transition model.

Findings in Relation to the Literature

A feminist lens on the lives of trans men. Scott-Dixon described the importance of framing 'trans' as "a social and political, rather than a medical and psycho-therapeutic, category" (p. 18), a lens which proved useful during this study. This shift in perspective brought to the forefront the stories these participants shared about the social experience of transition. In many cases their relationships with their families, friends and communities were difficult and challenging, but if the analysis stops there we are caught again in a circuit of pathology. As I describe in the next section, it was in part because of these experiences that participants showed how capable they were at setting goals for their transitions, and following through in the face of social and systemic adversity.

Raymond's (1994) perspective on 'transgender' demonstrates shortsightedness by focusing superficially on the components of transition: the clothing, hormones and surgical interventions. The participants in this study spoke about these as issues that are part of a greater narrative of being seen socially as men and/or gender non-conforming people and the implications on their safety. Raymond would have been wise to look at how these implements of transition contribute to the experience of gender, and to consider Lorber's (2005) ideas in order to explore how the gender binary informs the medical and non-medical choices trans men make about transition. Lorber was correct in her assertion that the gender binary plays a role in transition in that it defines the categories with which these trans men negotiated in their search for contentment. As the scope of inquiry grows wider, the landscape of gender broadens and allows theorists unique opportunities to unpack the socially constructed roles we all play and the effects on trans men of having been socialized as girls and women, whether or not they experienced themselves in that way; as participants described, for some there was early awareness of discordant gender while for others there was not.

Findings from this study, particularly regarding the “negative transition story”, support the research of Cole, Denny, Eyler and Samons (2000) and their assertions regarding the implications of language like ‘disorder’ and the ongoing pathologization of the medical model. Participants demonstrated the necessity of acknowledging what these authors referred to as “the in-between state” as a vital stop on their journeys, whether enjoyable or stressful. Like their early gendered socialization, these experiences needed to be integrated by participants in order to reach satisfied lives.

Satisfaction and subjective well-being. The overarching story shared by the trans men in this study is first and foremost that trans men can be satisfied with their lives and this is, according to my Advisory Group and participants in this study, is likely to be groundbreaking information for those invested in the dominant transition narrative. That this might be such a significant shift in thinking is something I can only attribute to the deep-seated societal belief in the pathology of trans people that stems from the institutionalization of mental illness in the *DSM-IV-TR* (2000). Even if gender identity disorder were removed from the manual, the lingering effects of ‘trans as a diagnosis’ will continue as we have seen with homosexuality’s inclusion and ultimate removal from the *DSM-IV-TR* (for a comprehensive discussion of this issue, see Drescher, 2009). Heterosexism is a fundamental social structure that benefits certain groups, and is reproduced in education, religion, law, the arts, and health and social services. Similar structures continue to function in relation to gender and the clear lines between the sexes; patriarchy and heterosexism are two examples, and transphobia a third. The “negative transition story” is evidence that medical institution considers trans men so mentally ill that the concept that they could be satisfied is a revelation. These participants are satisfied not just because they responded to a recruitment ad that used satisfaction as a criteria; they demonstrated their satisfaction in ways that are rather commonplace and not particularly unique to trans people.

Diener’s (1984) describes subjective well-being as having three criteria: it is assessed individually, comprises both helpful and lack of unhelpful factors, and is comprehensive. Participants provided critical self-assessments that were subjective,

clearly situated in their lived experience, considered both negative and positive factors, and were global in nature. The road to satisfaction was not always well paved for these trans men but with the support of their social networks, positive stories from select peers, and demonstrated self-efficacy, they made their own way. They spoke about self-actualization, the importance of relationships with friends and family, and of having a personal sense of power. Participants had purpose in their lives and their reflections, considered here, made it clear that they were invested in their personal growth.

Looking at the realms of life described by Ryff (1989) – self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth – participants demonstrated self-acceptance in the decision to begin transition and in their present post-transition experience. They spoke of the value and the importance of their relationships with family members, parents, siblings, partners and close friends, and with work colleagues who do not know that they are trans. Each of these participants established his autonomy by going his own way, defining his own path and working through the medical transition experience in a way that was self-affirming. Participants reflected on the value of integrating their lives prior to transition and the meaning this had to them in the present. They stated a desire to change the transition experience of others who might be struggling with their transitions, even if only by changing the dominant narrative about it; their participation in this study is a demonstration of this. Moreover, many stated that participation in this study was a way for them to contribute to trans communities in a way that was meaningful to them and enabled them to explore and reflect on their lives with others who share similar experiences.

Thus, based on the criteria set out by Diener (1984) and Ryff (1989), these trans men are satisfied. They maintain satisfying relationships with family, friends and partners, have stable home and work environments and do well at managing the minor everyday stresses we all experience. The roads that these trans men have traveled to satisfaction have in many ways been different; here difference speaks to a trans experience as much as to the individuality we all possess, trans and non-trans alike. How their experiences are different due to gender transition can teach us

a lot about how trans is socially constructed within our communities in general, and health care in particular.

Mental health and the DSM. Rarely does the health literature state that it is possible for trans men to move through transition in a good and timely manner with lots of support (Lev, 2004). For the participants in this study, hearing positive stories from other trans men was incredibly helpful and thus the documenting of these positive transition stories is vital in order to dismantle the “negative transition story.” These stories are in direct conflict with the dominant mental health framework, a hegemonic discourse that fosters a particularly unflattering narrative of transition with which trans men and service providers are forced to cope and contend. Documenting these stories is a first step toward shifting away from this troublesome narrative.

The *DSM-IV-TR* states “conflicts that are primarily between the individual and society are *not* mental disorders” (emphasis mine, American Psychiatric Association, 2000). Based on the stories shared by the participants in this study, the challenges and satisfaction trans men experience in their lives are predominantly a result of their social interactions, findings that raise serious questions regarding the continued inclusion of transsexuality as a mental health disorder, and which support the work of Hansbury (2005) and Lawrence (2007). Further, most participants’ lives were not so negatively impacted by their gender issues that they initiated their transition so as to meet the “D Criterion” of distress or significant impairment required for a gender identity disorder (GID) diagnosis. According to Cohen-Kettenis and Pfäfflin (2009), this issue is contentious within groups discussing the future of the GID diagnosis within the forthcoming DSM-V, and findings from this study support a reexamination of this criterion.

The other challenges that these trans men experienced fall within the range of what a non-trans person might experience and are, for the most part, not related to transition or being trans, but rather to how society responds to their gender. For service providers this understanding is key to shifting trans-related mental health care away from *disorder*, and toward addressing the external factors that influence and impact the individual, cause depression, anxiety and other social stressors. By

utilizing strengths-based practice (Saleebey, 1996) and understanding how trans men describe their subjective well-being, we can make significant inroads into improving access to mental health care.

Implications for Developmental and Identity Theory

Developmental and identity models by Lev (2004), Devor (2004) and Hansbury (2005) are helpful in unpacking some of the mental health issues presented by participants. Devor's (2004) discussion about the importance of mirroring provides insight into the frustration many participants shared about participating in trans communities and attending support groups. There they saw other attendees as witnesses, but did not desire them as mirrors; they preferred to model the "guys in the woodwork" as more successful, transitionally speaking. Located somewhere near Devor's tenth stage, *Delay before Transition*, and Lev's (2004) second phase of seeking information and reaching out, participants listened at the door of the trans community and heard the cacophony of the "negative transition story" and still persevered and moved ahead.

For some participants there seemed to be a further disjuncture between the stages of *Integration* and *Pride*: where does a trans man who is living stealth fit? How prideful is a trans man who is reluctant to share proactively his successful transition story with others? Separating from trans communities, or living stealth like the "guys the woodwork" is an option that some trans men choose. For participants who were the most disengaged from trans communities (despite participating in this study), there was clearly a sense of great satisfaction with life. Consistent with Hansbury's categories of identity (2005), these participants are more like the 'woodworkers' than 'transmen' or 'genderqueers' in that they identify as 'men,' live apart from the trans community and live rather conventional lives. Again, one must be cautious about any categorical assessment for the risk of created further binary thinking.

There is need to be cautious about using developmental models to create discrete and expected outcomes, and to recognize that trans men will move at different speeds and different ways along the spectrum. Language like 'success' and 'complete' when used in transition should be used cautiously, especially when they

imply 'passing' completely. Some trans men may choose to not pass for personal or political reasons while others simply are not able to pass due to genetic factors and biological responses to TRT; for these individuals the stigma continues. Further, assessing completion in terms of gender performance is problematic, as Hansbury (2005) explains:

The quandary is this: by setting up a system in which the final, triumphant goal is public pride and activism, FTMs who remain at the Integration stage – in the woodwork – may too easily be seen as developmentally stuck, as poor, misguided victims of the heteropatriarchy, suffering from internalized transphobia. (p.247)

'Woodworkers' within this study were neither developmentally stuck, nor victims of heteropatriarchy, thus sustaining Hansbury's caution. Some may be rightly concerned about how a person's mental health and well-being are affected when a large portion of their personal history and a major milestones of their lives goes unacknowledged, perhaps eventually becoming toxic. While I think that 'hiding' can be harmful and that pride and activism can be beneficial, I believe there is a space between these positions where a trans person may or may not disclose or act on political teaching moments presented in their everyday world.

Trans men in our study identified a wide range of life factors that related to their mental health and wellness. While identity models focus on the ramifications of being trans, they do not address all of a person's life. Transition-related concerns included: medical (hormones and surgeries) and non-medical transition options; 'passing'; trans-related 'coming out' to partners, friends and family, and concerns about loss of support; societal oppression due to transphobia; threats to socioeconomic security (e.g., housing, employment) because of discrimination; isolation and alienation; and internalized oppression. Issues identified by study participants that were not specifically related to transition included: body image; concerns with aging; substance use and recovery; dating and relationships with non-trans people (heterosexual and lesbian women, gay and queer men); sexual intimacy issues; and concerns about long-term use of hormones. Models of trans-identity formation need to operate more holistically in order to incorporate this

broader array of issues.

The concept of transition readability privilege (TRP) I described previously complements Krista Scott-Dixon's (2006) concept of 'gender privilege' in that it helps us understand why some trans men decide to disengage from trans communities. When trans men are read easily as men within dominant society they have the option of not retaining their trans identity, at least socially. Some seem to assimilate and live plainly as men, while others maintain their trans identity. Thus trans men who pass benefit from gender-based privilege in contexts like the grocery store and classroom, but not in others like the bedroom and the doctor's office. Those who struggle to pass, or who only pass some of the time, find themselves less able to go about their lives, let alone access health services, without the burden of transphobia to influence interactions. Privilege is never all-encompassing and the subjective experience of privilege is always individual.

Implications for Social Work Practice

When considering implications for social work practice, I have different expectations for generalist practice – the knowledge I would expect any social worker to have about trans people – than for specialist practitioners.

Strengths-based generalist practice with trans men. My expectation is that social workers need not just a general awareness of transgender issues but also sufficient competence to work in a respectful and appropriate way with a trans person in whatever program or capacity we might encounter them. We need to recognize that we may find ourselves working with trans people as clients, co-workers or superiors in almost any setting and client population. We need to recognize any anxieties we may have regarding gender pronoun preference and, using our communications skills, inquire with clients at an appropriate time and in a respectful way; we are unlikely to be the first person to ask this of our clients who present as gender non-normative, but we might be the first to inquire respectfully.

As Hansbury (2005) cautions, many trans men are apprehensive about accessing service due to concerns about mistreatment or inappropriate care, often based in their own experience. Therefore we need to consider how our own practice, or the programs we manage, in policies and procedures perpetuate the

dominant “negative transition story.” Further, we must be cautious that we are not making assumptions about trans clients’ experiences being necessarily negative, problematic or even associated with being trans at all. As with gender pronouns, we have the opportunity to create new experiences for clients that are based in respect and dignity when we shape our interventions in terms of resilience and coping. As the stories in this study have demonstrated, many trans clients have negotiated numerous systemic barriers and been forced to self-advocate for their healthcare.

There remains the need to consider the implication of being trans on more generic and mundane life experiences. For example, a trans man seeking medical attention for a broken arm may not require different medical treatment, but may still experience anxiety from the anticipation of being differently treated by health-care providers, even if this does not actually happen. The stress of anticipation or of needing to ‘come out’ as trans can make a mundane experience different. By providing an environment where trans clients are welcomed respectfully and appropriately treated, we can help alleviate this anxiety. This environment can be created using strategies Pazos (1999) described earlier – such as increased cultural knowledge of trans communities, use of psycho-education, and understanding client resistance – and by recognizing that trans clients, like all clients, benefit from support, recognition and flexibility from service providers.

As study participants demonstrated, having resources, both financial and social, helped them maneuver through their transition process and the healthcare system more easily. When conducting strengths-based assessment, such as the pragmatic framework offered by Graybeal (2004), we can help our clients identify and nurture these resources. Beyond resources, we can investigate options clients have for their transition process that perhaps had heretofore gone unexplored. We can think creatively about what clients imagine for and of themselves once they meet their transition-related goals. In times when the realities of the “negative transition story” are manifest, we have the option to explore how they may continue to thrive through these challenges just as they have in the past. And we can invite clients to consider what they most want for themselves, and what they might dream about on Saturday mornings as they lay in bed.

At the same time there is a need to understand that gender transition happens in the context of other identities and marginalized categories such as race, age and sexual orientation. Further, due to a dominant sexuality discourse that problematically lumps trans people together with gay, lesbian and bisexual people, gender identity and sexual identity are commonly confused, resulting in an ever-present and on-going marginalization of trans people today. As social workers we are especially well situated to help clients understand these issues, presenting us with a great opportunity to develop a deeper relationship.

Finally, providers who work with trans people in addictions can take insights from the stories shared here in order to understand that some degree of substance misuse may be directly related to trans clients' experiences of the "negative transition story." The tangible experiences of systemic barriers and social stigma can have an understandably detrimental impact on an individual's mental health and substances may be used in both helpful and unhelpful ways to cope with the resultant stress. With this understanding in mind, our role is to understand the societal contexts of our clients' struggles in relation to their personal life experiences.

Advanced clinical practice with trans men. For mental health or primary care practitioners specializing in transgender healthcare there are a broader, more challenging and exciting array of practice issues that arise from this study. The participants in this study made their transition a priority and had the privilege to do so. Some paid out-of-pocket for surgery because they were not willing to give up power over their own medical transition process and to be put on a provincial-health-insurance waitlist. They recognized surgery was something they wanted and found a surgeon to do it. Keeping in mind what study participants perceived as 'stuck in a middle place,' we can help clients assess any other concerns that might result in medical transition not being a primary interest for them. Not every transperson wants to, or is able to, prioritize transition as a foremost concern, so our assessment must also include awareness of clients' other priorities such as children and partners, competing health issues, and financial status.

Those people who are exploring their gender or considering transition may just listen at the door of the transition narrative and likely hear only the loudest

voices sharing the “negative transition story.” We have the opportunity to reframe that narrative and encourage clients to seek out other stories. To find positive stories took many months for some highly motivated participants, so we might refer clients to appropriate support groups where we know a balanced transition story is shared. Some might deny themselves transition and continue to live their lives while putting aside any thoughts of gender. The potential long-term negative impacts of denying gender identity on a person’s mental health are a grave concern and may lead to depression, anxiety and unhelpful coping strategies like substance abuse. As mental health workers we should assess for these as possibilities and treat appropriately.

In terms of transition, we understand that some of our clients may just want TRT while others also want surgical interventions. There is no predestined end-point other than finding greater comfort with oneself. Our colleagues and other practitioners may struggle to understand clients for whom testosterone, surgeries and passing are not priorities. Gender transition is a personal journey, one that may, but does not need to, focus on the polar ends of the gender binary. Wherever our clients find themselves on the spectrum is fine, and wherever they are at today is just perfect even when there is a desire to change and grow.

Further, participants described the potential for making the transition experience an enjoyable one. The question being posed to trans and non-trans friends, allies and service providers is this: will we continue to perpetuate the “negative transition story” or will we instead encourage a journey that, while still fraught with real obstacles and challenges, can be pleasurable for the individual, leads to a more satisfied life, and makes a positive contribution to all communities?

It is my belief that the movement away from gender identity disorder as the central focus in trans health care is a litmus test for all providers: those who maintain that trans people are essentially mentally ill are not allies of trans people. As programs like Callen-Lorde Community Health Center in New York City demonstrate it is possible to move away from using GID as the foundation of transition-related medical care in the United States (Douglass, 2009). Their *Informed Consent Model* is clearly more aligned with the Social Work Code of Ethics (BCASW, 2003) in that it puts the onus of responsibility and direction with the client and leaves the role of

social workers to simply assess capacity for decision-making and provide ongoing advocacy and support. I will propose an evaluation of current Canadian models later when I discuss future research directions.

Providers need to take a closer look at the assessment models currently used for trans people and move toward a more progressive and client-centred modality. We can explore options that might enable more clients to access the health care they desire. By shifting the focus away from treating transsexualism and toward helping our trans clients find a more comfortable way of being with themselves in their bodies, we end up with greater flexibility in our assessments and diagnoses. Any health-care intervention has the potential for generating stress related to disclosure and the potential for receiving treatment that is non-competent or explicitly transphobic. An additional challenge for service providers is to resist the assumption that GID is the foundation of all health issues experienced by trans clients. Beyond the potential stress experienced by the client, it may be easier for us to recognize how treatment for a broken arm does not fall under the GID umbrella of trans care; however it would be more challenging to assess chronic depression, anxiety, and dysthymic disorders that are clearly present in our trans clients, but not necessarily caused by or related to their being trans. The onus is on us as service providers to not take the easy diagnostic route. Can we imagine a clinical world where some of our clients may have mental illness and also, coincidentally, be trans?

As social workers, I believe we need to see the utility of using these research findings to inform practice, and as a means of engaging with our clients in ways that we otherwise might not. It is possible that as a clinician I might never see people like those I interviewed. These trans men are not in need of our services and thus may never enter a clinic or program where a social worker is employed. By identifying an optimum state of well-being, and an end-goal for practice such as life satisfaction, I was able to learn about what that particular 'destination' might look like and, perhaps more importantly, understand better the journey. From here I can generate more informed, outcome-based goals with clients who may be starting and struggling with similar journeys.

In terms of working with trans men around addiction issues, some might think that concurrently broaching and even initiating transition would be foolhardy. As participants' stories underscored, engaging with trans men about their gender has the effect of reducing mental health symptoms. My recommendation would be that as practitioners the onus is on us to unpack and dismantle the "negative transition story" during counseling in order to de-escalate any possible triggers or concerns our clients may have.

An assessment tool for transgender-related stress and trauma. Mental health concerns like depression, anxiety and substance abuse experienced by a trans person may or may not be related to gender identity issues, particularly when those concerns involve societal oppression. As previously stated by Lev (2004), one of the reasons trans clients seek help is to address gender-related distress. She argues that the fear trans people have for transgressing normative gender behaviours, and the long-term performance of a false self may actually cause mental health issues (p.196):

The high incidence of mental illness among transgendered people noted in the literature might be better understood as reactive symptomology and posttraumatic sequelae. It is literally *crazy-making* to live a false self. (p.196, original emphasis)

Lev suggests that these illnesses might actually be expressions of deep-seated trauma. This approach reveals transgenderism and 'Gender Identity Disorder' as expressions of mental health symptoms and substitutes these with an etiological view of Post-Traumatic Stress Disorder (PTSD). PTSD is another DSM-IV-TR diagnosis familiar to practitioners that comes without the burden of the gender-related stigma. The key then, if the foundations of transgender mental health are based in PTSD, is for service providers to explore these issues with their trans clients in order to provide effective treatment.

This Assessment Tool is intended for use by social workers, counselors, and other healthcare clinicians who assess or treat transgender men and other gender non-conforming with regard to mental health and wellness. Wherever clients are in their transition journeys, this tool is intended help professionals create an

environment where trans individuals can explore their experiences. Peer counselors and group facilitators may also find it useful.

Why is this tool important? Many trans people are not open about their gender identity in mainstream treatment and counseling facilities for fear of maltreatment or negative attitudes from staff and other clients (Raj, 2002). Programs for trans men and gender-variant people need evidence-based tools to help assess and support individuals during and after transition. Even clinicians with a strong understanding of gender identity issues may lack a repertoire of appropriate questions to ask about gender identity. Others may be unaware of why such questions are necessary for clients of substance abuse and/or mental health services.

Emergent life factors. Trans men in our study identified specific life factors that related to their mental health and wellness. Transition-related concerns included: medical (hormones and surgeries) and non-medical transition options; 'passing' and being read as their affirmed gender; trans-related 'coming out' to partners, friends and family, and concerns about loss of support; societal oppression due to transphobia; threats to socioeconomic security (e.g., housing, employment) because of discrimination; isolation and alienation; and internalized oppression. Non-transition-related issues identified by study participants included: body image; concerns with aging; substance abuse and recovery; dating and relationships with non-trans people (heterosexual and lesbian women, gay and queer men); sexual intimacy issues; and concerns about long-term use of hormones.

Awareness of unresolved issues stemming from transition is vital to effective treatment and counseling. Until now the impacts of transition-related stress and trauma have not been adequately described (Lev, 2004), nor have interventions been created to effectively address these. By using this tool, counselors have the opportunity to develop deeper rapport by identifying and supporting issues that are unique to the transition experience. While this tool was developed based on evidence from a research project focused on trans men, counselors working with trans women may also find this helpful.

Assessment tool questions. This assessment tool includes a set of six open-ended interview items (Table 1) to be asked by the counselor during assessment or group process. These questions are informed by a strengths-based model commonly used in social work practice (for a primer on strengths-based practice, see Graybeal, 2004). Questions were crafted using culturally-specific and trans-affirming language for engagement with trans people, and designed to be asked in a particular order. While counselors and facilitators will use their own style, the rationale for each question explains the important elements of each.

Table 5.1 An Assessment Tool for Therapeutic Exploration of Narratives with Trans Men

1. Identifying transition-related narratives.

- What are the stories you have heard about transition?
- How accurate are/were those stories?
- How much influence do/did you have in shifting those stories?
- How do/did you experience your power?

2. Contextualizing hormones and surgeries among other transition-related options

- What do/did you see as the options for transition?
- What options do/did you want, what are/were you considering, and what do/did you **not** want for yourself?
- What significance do/did or don't/didn't hormones and surgeries have in your transition experience?
- Setting aside hormones and surgeries, what are/were the important milestones on your journey?

3. Identifying key social supports and their contributions.

- Which supports are/were most helpful in your transition?
- In what way were they helpful?

4. Illustrating capacity for self-efficacy.

- What strategies do/did you use to manage any barriers or challenges you experienced?

5. Unpacking the emotional impacts of privilege or disadvantage.

- What opportunities have/did you take/n advantage of to further your transition?
- What feelings do you attach to these?

6. Creating tangible strategies to generate new transition narratives.

- What is it about your transition story that might be helpful for other trans men to hear?
- How might you go about sharing your transition story in a concrete way that benefits other trans men?

Question 1 - Identifying transition-related narratives. These questions being the process or storytelling and help individuals unpack the competing and likely difficult components of the transition narrative including the “negative transition story” described in this study. Clients assess these stories and situate themselves within these narratives as a subjective entities.

Question 2 - Contextualizing hormones and surgeries among other transition-related options. In this section, clients begin to explore the menu of options that transition has available. Many will see TRT and surgeries as the foundations for their transition experience. The intention is to look at what components individuals include in their visions of gender transition, including changes to the body that will make living in it more comfortable. Medically-mediated gender reassignment interventions are contextualized over a broader realm of choices. The importance of being ‘read’ as the affirmed gender and the understanding of potential biological and genetic limitations to doing so are explored.

By asking what the client does and does not want creates an opportunity to explore a client’s decision-making process and their feelings related to each option. The final question asks clients to set aside hormones and surgery specifically, thereby revealing how the dominant transition narrative tends to favour discussions of hormones and surgery. This gives the practitioner the opportunity to investigate with clients what other significant events and experiences impacted their transition. In this way we begin to poke holes in the dominant narrative and allow a new and personalized transition story to emerge.

Question 3 - Identifying key social supports and their contributions. With these questions individuals can speak about the social supports that are important to them, and qualify how these relationships are made meaningful. They discuss the specific actions and events, and the insights they may have in relation to these.

Question 4 - Illustrating capacity for self-efficacy. With these questions, clients explore specific instances where they demonstrated resilience, and how these previous experiences confirmed the client’s ability to cope with the challenges they may face in the future.

Question 5 - Unpacking the emotional impacts of privilege or disadvantage. By discussing how they mobilized any privilege they experienced, clients demonstrate self-efficacy but may also reveal unexpressed emotions like guilt or anger toward their social networks, trans and broader communities. This question may be the climax of the narrative and therefore open the deepest emotions.

Question 6 - Creating tangible strategies to generate new transition narratives. Finally, clients have the opportunity to consider, in the context of problematic narratives, that they can create new ones. Further, they can act on these in tangible ways.

Implications for Research

Reflections on my research methods. On the whole I believe this was a successful research project. Holding both focus groups and individual interviews helped build trust and deepen the relationship between participants and myself as researcher. Participants heard a testimonial about my competence and ally-sensitivity from a recruiter, exchanged organizational emails and telephone calls with me, and spent 90 minutes in the focus group I facilitated before attending a one-on-one interview; this range of social interactions helped to increase rapport and contributed to the depth of disclosure I experienced with participants. This relationship which I established with each participant while maintaining appropriate and ethical boundaries, contributed significantly to the validity of this research.

Method. Conducting research in a small community presented some unique issues and challenges. It was made clear to me by my Advisory Group that an impersonal and blanket email sent to a trans community email list would not be an effective method for recruitment. Their caution was based on the deluge of such requests they had seen. By providing a personal testimonial and making individual contact with potential participants, the recruiters were not only effective in finding amenable and appropriate individuals, but also began building rapport between me as the researcher and participants. I would encourage future researchers working with trans or other small communities to identify and engage community leaders as recruiters for just this reason. I would advise researchers to disclose their own social locations and investment in the research, state clearly the intent of the project and

the anticipated use of the data. Trans men have become sophisticated consumers of research because many of these men are already looking to the literature to help them educate themselves and their health-care providers. By asking third-party recruiters to provide accurate testimonials I believe researchers will increase participation and community investment in their work

Another valuable lesson I took from the two focus groups, and which may inform future research, involved the first question, or the question of entrée. At the first focus group my first question was “What brought you here to this research focus group tonight?” This question elicited from participants some common reasons for taking part in the study and created some early group cohesion. At the second focus group, I unintentionally skipped that same opening question and went immediately to the question about the personal memento they had brought. What I observed was a greater reticence and reluctance among participants to share their experiences. I looked to my research assistant and without dialogue we seemed to agree that there was an odd flavor to the group. Once it occurred to me that I had skipped the first question, I returned to it and immediately saw the same synergistic effect I had observed at the first focus group.

Ethics. As I discussed in the Methods chapter, maintaining participant anonymity was structurally undermined by my decision to hold focus groups; here I could request, but not guarantee that participants maintain the confidentiality of others once they left the room. Further, I knew that despite my efforts at anonymizing participants’ stories in this and future documents, it was possible that community members or others may recognize these stories and thereby identify participants.

I could not have anticipated what would happen if I attended a regional conference where study participants were present and recognize that by discussing this I may increase the risk of participant identification. Do I name a conference and thereby limit the pool of potential participants, knowing that the number of Vancouver-based attendees is likely both small and close-knit? What would happen if participants identified themselves openly? What might I say to a participant whose stories informed this research, but whose individual story was not represented in my

presentation in the interest of brevity? These questions highlight the uniqueness of the small community research situation and, for me as researcher, the delicate dance I must perform in order to maintain the ethical integrity of the research project. I recognized that I had already been managing relationships with participants when I checked with participants about the stories I included here as a method of validating my findings.

In the case of Ed, for example, I was nervous about including his disclosure regarding sexual confidence. While I had his consent to use the data, the tone with which he spoke left me with the impression that this was deeply personal. These were important flags for me to include this information. I also wanted him to know the reason I intended to use this information, what I thought it meant, and how I saw it fitting into the larger context of the study. Ed and I had a thoughtful conversation about this issue and, while he remained somewhat sheepish about the subject, he agreed with my interpretation.

Finally, throughout this study I have harboured a concern about how participants will be perceived; one of the by products of a dominant health literature that pathologizes a community is that community members are rarely viewed as healthy or happy. Let me state plainly: any doubt we might have about the satisfaction experienced and expressed by the participants in this study is grounded in a value judgment. In a world where an abiding principle is that we just want what is best for one another – a satisfied life – these participants say they have that. Any reservations we may have are more a mirror of our own bias and have nothing to do with these participants.

Validity of findings. In this study, I engaged in verification of the findings by asking participants to reflect on interpretations of the focus groups at their individual interviews and by checking my interpretations with the Advisory Group and with trans men who attended conference presentations I gave on these data at the Philadelphia Trans-Health Conference in June 2009, and at the Gender Odyssey and Southern Comfort Conferences, in Seattle and Atlanta respectively, both in September 2009.

Madriz (1998; 2000) writes about the positive impacts that bringing members of

an oppressed group together can have in terms of validating experiences and feelings. Within this study, evidence for just these kinds of benefits comes from the transcriptions of the focus groups, the observational data collected from them, and the feedback shared by participants at their individual interviews.

Reissman (2003) states that, “the truths of narrative accounts lie not in their faithful representation of a past world, but in the shifting connections they forge among past, present and future” (p.341). I embarked on this research process aware that participants, or myself as the inquirer, might be tempted to enhance the experiences of satisfied trans men, as implied by the research question, in order to present a rosier picture of trans people that would stand in contrast with the extant literature. Part of the reason for choosing the language of ‘satisfaction’ rather than ‘happiness’ was to avoid a good/bad dichotomy from affecting the stories; even so, some participants initially framed their responses within this kind of binary; I recognize that I have perpetuate this binary myself with discussion of positive and negative transition stories. For example, during an individual interview one participant expressly stated that he thought he could only share positive stories, inferring this from the recruitment call for individuals who were “generally-satisfied.” Despite this one participant’s comments, what became clear in the analysis was that, even if the intent was positive, participants revealed stories of the challenges they faced personally, within social networks, and in their communities. As Diener (1984) suggests, and participants demonstrated, both strengths and satisfaction are contextual. Over the course of the focus groups and interviews, I listen as participants identified strengths-based categories such as available supports and resources, problems and self-generated solutions; this was a way of reframing that is effective in practice and, arguably, in my estimation is valuable in a research setting as well.

Future research directions. This study is a beginning, an introductory strengths-based look at the lives of trans men that answers a few questions while asking many more. Opportunities for future research include conducting longitudinal studies of trans men at the early stages of their transition decisions and following their progress within a program that highlights the individual and social transitions

over the medical ones. Such a cohort would present further challenges to small community research, but also exciting possibilities about testing community-based interventions that could improve the holistic health of participants and potentially identify emerging new practices for working with trans communities.

In light of the *Informed Consent* model for hormone assessment used at Callen-Lorde (Douglass, 2009), one piece of research that needs to be completed is to explore further the current Canadian assessment models used by providers at agencies such as Three Bridges Health Clinic in Vancouver, the Sherbourne Centre and the Centre for Addictions and Mental Health in Toronto, as well as the GRS Clinic in Montreal. A review of assessment models could identify where these contribute to the “negative transition story” and where they address trans-related issues and those that are related to societal oppression. Emerging from this evaluation could be a Canadian assessment modality. With the advocacy and support of organizations such as the Canadian Professional Association for Transgender Health and EGALÉ (Equality for Gays and Lesbians Everywhere), this could ensure a more progressive, client-centered and trans-competent model is used nationally. This would require frontline service-provider training, as well as negotiation with governmental agencies such as the Provincial Health Insurers and the Provincial and Territorial Ministries of Health who stipulate policies about transgender health. There may be options to use alternative diagnoses to assist trans clients’ access to healthcare, thus and it would be necessary to assess the current billing practices, and the flexibility and options therein, for each province and territory. I believe this work would add to a growing extant literature on access to healthcare for trans people in Canada (Taylor, 2006).

A comparative analysis of healthcare access between Canada and the United States might also prove insightful. While Canadians have access to universal healthcare, access to trans healthcare varies by province as previously described. In the United States, the healthcare and social-welfare systems are significantly different and access to trans-specific services all the more challenging. Valuable lessons that benefit trans people and inform providers on both sides of the 49th parallel should emerge.

We all, trans and non-trans, undergo physical transitions as we grow older and watch our bodies change. Another area for research is in regard to aging. In the study Ed spoke of two transitions, only one of which is influenced by the impact of testosterone, while the other is impacted by genetics, environmental influences, health and wellness. There is a need for further clinical study regarding the long-term impacts of testosterone use and its associated co-morbidities. My study demonstrates an equally important need to identify the long-term health and social benefits of being a generally satisfied trans man.

Conclusion

Transition is not the journey: life satisfaction is. On the road to satisfaction there is a stretch of highway that involves coming to terms with one's body. I hope that this study has provided some valuable insights into the description of a problematic dominant narrative about transition and the highly problematic impacts of this discourse on the everyday lives of these participants. Trans men can have both enjoyable transition experiences and lead contented lives. From this research, I am convinced that my role as an ally and social worker is to break down the "negative transition story" and remind my trans men friends and clients of a better, more positive and fulfilling opportunity to transition in a way that foregrounds the personal and social over the medical, and leads to an overall more enjoyable experience for the individual, his family, friends and supporters.

When I began this study to explore the stories of satisfied trans men, I had not anticipated the focus would be on issues (mostly positive) of transition as expressed retrospectively by post-transition trans men. From the stories collected at focus groups and individual interviews grew a broader narrative across and about these particular participants' lives. This narrative not only resonated with the study participants and the Advisory Group, but also with many of the trans men I met in the summer of 2009 as I presented early versions of this research at conferences across Canada and the United States. Today I look forward to sharing these findings with other mental health providers and clinicians invested in transgender health. Through research presentations to policy makers at regional health districts, and papers presented to clinicians and researchers at conferences and in peer-reviewed

journals, the voices of these trans men will echo for many years to come. In the spring of 2010 I plan to coordinate with members of my Advisory Group a trans-community health day where the stories will come full circle and be shared with the communities that informed this study. I expect some of the participants will sit in the audience and I can only hope they are as satisfied as I am grateful about their contributions to this project.

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APPENDICES

Appendix A – Promotional Flyer

THE UNIVERSITY OF BRITISH COLUMBIA

THE FRED STUDY

Are you a Trans Man?

Are you satisfied with your life?

We'd like to hear the story of your journey.

What's involved?

We'll ask you to attend a 90-minute focus group of four or five guys, and a follow-up, one-hour individual interview a few weeks later. You'll receive \$10 for attending the focus group, and another \$20 for the interview. We'll also reimburse your parking or public transit costs and express our sincerest gratitude.

This study will inform a Masters thesis project, and is supervised by Principle Investigator Dr. Brian O'Neill of the UBC School of Social Work

Interested?

If you'd like to learn more about this project, please contact: **Marcus Greatheart** at greatheart@gmail.com or (778) 991-7510.

Appendix B – Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA



School of Social Work
2080 West Mall
Vancouver, B.C. Canada V6T 1Z2
Tel: (604) 822-2255 Fax: (604) 822-8656
www.swfs.ubc.ca

CONSENT TO PARTICIPATE

The Fred Study:

Exploring Trans Men's stories of life satisfaction, mental health and wellness

Principal Investigator:

Brian O'Neill Ph.D., RSW
UBC School of Social Work, UBC
Phone: (604) 822-2460

Co-Investigator:

Marcus Greatheart, BA
Graduate Student, UBC School of Social Work

We are seeking input from transgender (trans) men about their life satisfaction, mental health and wellness, and coping strategies. We are trying to better understand trans men's lived experience of wellness in order to inform the community about what makes trans men healthy. This knowledge will be used to help develop tools for service providers to support trans men more effectively.

Participation will involve attending a **90-minute focus group** of four to five trans men that will be facilitated by the Co-Investigator, followed by a **one-hour follow-up individual interview** a few weeks later. Both the focus group and the interview will provide opportunities for you to share your stories and talk about how you define life satisfaction. We are particularly interest in stories of resilience and strength in the trans community. We'd also like to hear about how you coped with some of life's challenges, and how substance use may have been a part of those experiences.

The focus group will take place in a private setting at a community agency, and the interview at a location of your choosing. At the focus group, we will ask generally about how participants define life satisfaction and if there are any common challenges. We'll also ask you to bring with you an item that represents your journey. If you are agreeable, a follow-up interview will focus on clarifying information obtained during the focus group and going a little deeper into your own story.

With your permission, **all conversations will be audio recorded and transcribed** with identifying information removed. We will provide you with a copy of the transcript in order to clarify or remove any information you do not wish to have included.

Your participation in this study is voluntary. You will be free to withdraw from the project at any time. You have the right to refuse to answer any questions and to withdraw any information you do not wish to have included in this study. Withdrawal or refusal to participate will in no way jeopardize your involvement with any available support programs. Moreover, unless you specify otherwise in writing, your input will remain confidential. This will be done by removing all identifying information from your files and using a pseudonym to reference you. Files will be stored in a secured location separate from any information that might personally identify you.

We recognize that sharing stories about our lives, particularly some of the challenges we have faced, may be distressing. We will be prepared to stop the interview immediately upon request. We are also prepared to help you locate appropriate support if this study is unsettling.

Also, although every effort will be made to preserve your anonymity and confidentiality, because of the nature of a focus group, we cannot guarantee confidentiality of what is said by focus group members afterward, even when we request everyone keeps what is said confidential. Also, due to the small size of the trans community, it is possible that small details could reveal a participant's identity. We have invited an Advisory Group of trans men to review anonymous summary reports of information we collect in this study. Their role is to help ensure the information and recommendations generated from this study remain grounded in the lived experiences of trans men. The Advisory Committee will also sign Confidentiality Agreements.

If you have any questions regarding this study, please contact Dr. Brian O'Neill at (604) 822-2460 or Marcus Greatheart at (778) 991-7510 or greatheart@gmail.com. Furthermore, if you have any concerns regarding your treatment or rights as a participant in this project, contact the researchers or the Research Subject Information Line at (604) 822-8598 or email to RSIL@ors.ubc.ca.

Thank you for considering involvement in this project. If you agree to participate, please provide your signature below.

Sincerely,
Brian O'Neill and Marcus Greatheart

I hereby consent to participate in the study described above. I have received a copy of this consent form.

(Name - please print)

(Signature)

(date)

Appendix C – Focus Group Questions

1. What brought you here to this research focus group tonight?
2. Describe for the group the item you've brought with you and how it represents your journey.
3. Who are the support people you have in your life?
4. What resources do you have available?

**Approval is issued on behalf of the Behavioural Research Ethics Board
and signed electronically by one of the following:**

Dr. M. Judith Lynam, Chair
Dr. Ken Craig, Chair
Dr. Jim Rupert, Associate Chair
Dr. Laurie Ford, Associate Chair
Dr. Daniel Salhani, Associate Chair
Dr. Anita Ho, Associate Chair