Learning from Transmasculine Experiences with Health Care: Tangible Inlets for Reducing Health Disparities Through Patient–Provider Relationships

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Abstract

Purpose: We examined health care experiences of transmasculine young adults to clarify factors contributing to mistrust in the health care system and identify tangible and modifiable means to address health disparities through improved patient–provider interactions. Thematic analysis highlights patterns within historical relationships between medical models and transmasculine embodiment, and provides guidance for health care clinicians, researchers, and policy makers to deliver competent services for transgender and gender diverse (TGD) individuals.

Methods: The study team used qualitative methodology guided by interpretive phenomenological analysis. Semistructured interviews with 12 participants who self-identified as transmasculine were conducted, transcribed, and coded thematically.

Results: Participants were a community sample of 12 young adults 18–35 years of age (M = 23, standard deviation = 3.74), who self-identified as transmasculine. Three participants identified as a racial/ethnic minority. Participants were highly educated, with most completing at least some college. The superordinate thematic domain Perspectives on Health Care emerged, under which three subthemes were nested: (1) an essentialist, binary medical model is inaccurate and oppressive, (2) consequences of medicalizing gender (i.e., gender as a diagnosis), and (3) recommendations to improve health care.

Conclusions: Qualitative analysis revealed specific ways in which the relationship between transmasculine individuals and current health care systems are fraught with difficulties, including the impact of stigma, gatekeeping, and inaccuracies, in current diagnostic criteria. Participants shared lived experiences and offered innovative ideas to improve health care delivery, such as challenging socialized biases, increased education, and immersion in TGD communities to advocate for change in research, practice, and policy.

Keywords: transgender health; access to care; transmasculine identity; social determinants of health; health disparities; resilience

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Introduction
Transgender people are estimated to comprise 1.4 million individuals within the U.S. population.1 This is likely an underestimate, considering the stigma associated with reporting transgender and gender diverse (TGD) identities. Moreover, inadequate tracking omits TGD identity designation in research and practice. This stigma and omission may be based in essentialist assumptions, which hold gender identities and expressions as binary, fixed, and entirely derived from biological sex, rather than a diverse or socially constructed phenomenon. That is, the outward appearance of genitalia at birth determines one’s sex, gender identity, gender expression, and sexuality.2–4 Although the essentialist paradigm can be useful for scientific classification, the application is restrictive when applied to the complexity of sex, gender identity, and expression. Consequently, essentialism disrupts TGD individuals’ relationships within the health care system.3

Data gathered from the 2010 National Transgender Discrimination Survey (NTDS)5 revealed that TGD clients reported negative interactions with providers at staggering rates. Reports included lack of provider knowledge (50%), harassment (28%), refusal of care (19%), and violence in medical settings (2%).5 These reports highlighted a substantial gap between best practice and current practice, and suggested that the health care system requires substantial training, transformation, and engagement with the increasing body of empirical literature supporting TGD health to provide competent care for this growing population.

These negative encounters in health care may be underpinned and exacerbated by essentialist assumptions.6–8 Furthermore, they exemplify what minority stress theory categorizes as “distal stressors,”9 and may have physical ramifications. For example, when encountered, distal stressors can initiate a repeated triggering of autonomic nervous system and hypothalamic-pituitary-adrenal axis responses,10 with cumulative effects leading to increased risk for chronic health conditions and accelerated aging (i.e., weathering).11 Related to this, research suggests that TGD individuals experience chronic health conditions (e.g., hypertension, diabetes, obesity, stroke, depression, and post-traumatic stress disorder) at higher rates than cisgender peers.5,12–14

Effects also play out on a practical level, with 33% of TGD respondents in the NTDS postponing preventive care and 28% avoiding health care altogether for fear of discrimination and mistreatment based on their gender identity.5 Another study found 40% of TGD elders feared accessing health care services due to discrimination and internalized stigma (both modifiable factors that intensify chronic stress).13 Undoubtedly, health care providers are instrumental to reducing disparities and facilitating favorable health outcomes for TGD people.

Recent diagnostic changes reflect health care’s shifting views of TGD identities. Particularly, TGD identities are no longer viewed as a pathological mental illness. Rather, in 2012, the World Professional Association for Transgender Health (WPATH) recommended that clinicians address psychological distress associated with stigma and discrimination when necessary, and ensure access to care based on an informed consent.15 In addition, in its 2019 revision to the ICD-11, the World Health Organization (WHO) re-classified “gender identity disorder” as “gender incongruence” and moved it from “Mental and behavioral disorders” to a new chapter entitled “Conditions related to sexual health.”16,17 Despite acknowledged imperfections, the WHO posited this revision is a step toward de-pathologizing TGD identities, while allowing access to affirmative care.17–19

This project examined health care experiences of transmasculine young adults to clarify factors contributing to minority stress and resilience, and identify ways to improve patient–provider interactions. Researchers extracted data from a larger, overarching qualitative study that highlighted how transmasculine young adults defined the term “transition,” and made meaning around concepts like gender, intersectionality, and the process of transmasculine identity development. Here, themes regarding perspectives on health care are presented. Rather than proceeding with a preconceived hypothesis, we phenomenologically allowed themes to emerge.

Method
A qualitative approach was used for the overarching study, guided by interpretive phenomenological analysis (IPA).20 IPA examines how people make meaning of significant life experiences on individual and group levels, and is based in three philosophical tenets: (1) phenomenology, (2) hermeneutics, and (3) idiography.20,21 All research activities were approved by the University of Wisconsin-Milwaukee Institutional Review Board.

Recruitment efforts included personal visits to Midwestern LGBTQ community centers, and outreach to various online social media groups. Overall, 15 people responded to postings, and 12 met inclusion criteria (e.g., 18–35 years of age, self-identifying as transmasculine). Data used in this study were derived from the same 12 participants (Table 1). Reasons for exclusion included
not self-identifying as transmasculine, not meeting the age requirement, and interest in participation after data collection concluded. Participants were interviewed in safe settings, including library study rooms, university spaces, and secured online video conferences, such as Zoom.

Data collection
Data were collected with semistructured, one-on-one interviews between the lead researcher and participants. We selected this approach for flexibility that allowed unexpected, meaningful dialogue to emerge. Researchers developed an open-ended interview guide to facilitate explorative free-flowing narratives, while remaining focused on topics of inquiry. This format allowed for (1) seamless movement from one topic to another, as unexpected conversational shifts are noteworthy in IPA analysis, and (2) participants as experts, leading researchers to thematic illustrations of "the thing itself." Topics broadly explored included identity development, intersectionality, meaning making, and experiences in health care systems.

After obtaining informed consent, the interview process focused on building rapport, while gathering demographic data. Interviews were audio recorded and transcribed verbatim for analysis. After transcription, participants were asked to review their transcript and encouraged to provide feedback. Two participants responded with edits (e.g., elaborations and typo corrections). All approved their transcriptions. Participants received $20 cash remuneration.

Research team
Two advanced doctoral level counseling psychology students were hand-picked to assist with data analysis, as they had extensive multicultural training, which included issues relevant to TGD identities. In the spirit of reflexivity and transparency, the team discussed intersectionality of their own identities, and how they may shape the analytical lens, which included (but were not limited to) the following: transmasculine, cisgender, female, white, 30–40 years of age, and queer. All team members were experienced qualitative researchers. The lead researcher provided mentorship specific to the IPA approach, emphasizing a safe and open climate, wherein researchers were encouraged to express ideas and challenge one another on potential blind spots. Researchers unanimously agreed that reflexivity, respect, active engagement in difficult dialogues, and bracketing preconceived ideas in analysis were critical to the research process.

Data analysis
As per IPA principles, analysis was neither fixed nor rigid, but comprised a common procedures set and commitment to illustrating group-level themes with idiosyncratic, individual experiences. Because 12 participants was large for an IPA sample size, we developed an analysis plan adapted from Smith et al., which adhered to core IPA principles (Fig. 1). The team repeated the steps until saturation was reached.

Our large sample allowed tabulation of cross-case thematic recurrence rates. Measuring recurrence supports the validity of findings, as it quantifies reports of a particular phenomenon across participants. For this study, designation of superordinate domain was set at a stringent 100%, meaning that subthemes must have appeared in all 12 narratives to meet criterion. The recurrent designation for subthemes was set at a rate of >50%, that is, for a subtheme to become

Table 1. Demographics

| Participant | Age | Pronouns | Gender identity | Race/ethnicity | Education (highest level) |
|-------------|-----|----------|-----------------|---------------|--------------------------|
| 1           | 25  | He/him/his Transmasculine | Mixed (e.g., African American, Irish, German, Cherokee, French) | Associates degree |
| 2           | 23  | He/him/his Transmasculine | White | High school diploma |
| 3           | 26  | He/him/his Transmasculine | White | Bachelor's degree |
| 4           | 19  | He/him/his Transmasculine | Black/African American | Undergraduate college student |
| 5           | 25  | They/them/their Trans Person/Genderqueer/Transmasculine | White | Bachelor's degree |
| 6           | 26  | He/him/his Transmasculine | Brown/Latinx | Graduate student |
| 7           | 21  | He/him/his Transmasculine | White | Undergraduate college student |
| 8           | 18  | They/them/their Transmasculine | White | Undergraduate college student |
| 9           | 20  | They/them/their Transsexual/Transmasculine | White/Euro American | Undergraduate college student |
| 10          | 30  | They/them/their Transmasculine | White | Doctoral-level student |
| 11          | 19  | He/him/his Transmasculine | White | Undergraduate college student |
| 12          | 26  | He/him/his Trans Guy/Transmasculine | White/Irish, Scottish | Bachelor's degree |
recurrent, it must have appeared in at least 7 of 12 transcripts (Table 2).

Data trustworthiness
To broaden trustworthiness (i.e., validity), individual quotes substantiated themes at the group level. Participant feedback was encouraged to ensure accuracy of data, interpretations, and representativeness of experiences. Researchers continually balanced reflexivity and subjectivity throughout the analytic process. Frequent research meetings allowed expression of multiple viewpoints, expectations, and preexisting notions. Differing narratives on the same topic were examined, with emergent subthemes and superordinate domains calibrated accordingly. Transparency guided the analytic process, and researchers followed steps to demonstrate credibility and applicability (Fig. 2).

Results
Demographic characteristics
A community sample of 12 young adults self-identifying as transmasculine and between 18–35 years of age ($M=23$, standard deviation = 3.74) participated in the study (Table 1). Three participants identified as a racial ethnic minority (mixed race/ethnicity, Brown/Latinx, or Black/African American). Participants were highly educated, with most completing at least some college.

| Emergent theme | Present in over 50% of sample |
|----------------|-----------------------------|
| 1. An essentialist, binary medical model is inaccurate and oppressive | Yes (83.3%) |
| 2. Consequences of medicalizing gender (i.e., gender as a diagnosis) | Yes (58.3%) |
| 3. Recommendations to improve health care | Yes (75.0%) |

Table 2. Thematic Recurrence

| Superordinate domain: Perspectives on Health Care (100% reporting) | Participant |
|------------------------|-------------|
| 1. An essentialist, binary medical model is inaccurate and oppressive | X X X X X X X X X Yes (83.3%) |
| 2. Consequences of medicalizing gender (i.e., gender as a diagnosis) | X X X X X X Yes (58.3%) |
| 3. Recommendations to improve health care | X X X X X X X X Yes (75.0%) |
Thematic outcomes
From the full analysis, Perspectives on Health Care arose as a superordinate domain and is the focus of this article. Three subthemes comprise this domain: (1) an essentialist, binary medical model is inaccurate and oppressive, (2) consequences of medicalizing gender (i.e., gender as a diagnosis), and (3) recommendations to improve health care.

Subtheme 1: An essentialist, binary medical model is inaccurate and oppressive
Participants described experiences with a health care system that largely reifies an essentialist, binary sex/gender framework, and found case conceptualization through an essentialist framework to be inaccurate and contrary to affirmative health care. For example, participants found binary categorizations of sex and gender erroneously simplistic, leading to the common, fundamental mistake of muddling constructs of sex and gender. These limitations resulted in negative experiences with providers, often leaving participants in the position of educating providers, vulnerable, invalidated, and cautious. In addition, when seeking physical transition-related care (e.g., hormones), participants often received messages that they were “not trans enough” and would be denied care if they did not meet cisgender expectations of men/masculinity. Moreover, participants viewed transition as a lifelong process encompassing many psychosocial facets, rather than a “one and done” treatment. Participants illustrated the impact of systemic oppression (e.g., binary only options on clinical forms), representing a large misalignment between the current health care system and TGD well-being.(Table 3).

Subtheme 2: Consequences of medicalizing gender (i.e., gender as a diagnosis)
Participants discussed the diagnosis “gender dysphoria,” and resultant stigma around TGD identities. Externalizing stigma was taxing and ongoing. Participants did not view all transmasculine experiences as dysphoric, yet they felt pressure to placate providers by emphasizing dysphoria and/or identifying with cisgender binary standards to access care. Contrary to
Table 3. Perspectives on Health Care

| Subtheme characteristics                                                                 | Participant quotes                                                                 | Participant quotes                                                                 |
|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| Roots of deleterious gatekeeping practices are tied to essentialist, binary assumptions   | I’m always kind of concerned that I’ll be seen as not trans enough, and they’ll be like, “You can’t go on testosterone” or something. But that is probably just my brain thinking of worst case scenarios… I don’t know. I don’t think people have to be hypermasculine. I think everyone should just be themselves. And you shouldn’t deny people medical help for that. And if you’re a trans man and you never transition medically and stuff… like if you don’t even change your name. Maybe you have a gender-neutral name assigned at birth and you never change anything. It’s just the same you’re still trans. |
| Systemic oppression rooted in essentialist, binary assumptions                              |                                                                                     |                                                                                     |
| Pressure to present as “trans enough” by way of essentialist standards to be deemed valid and/or access appropriate health care generates fear, frustration, and anticipated threat |                                                                                     |                                                                                     |
| Medical intervention assumed to define transitioning process; however, interventions are only one potential facet |                                                                                     |                                                                                     |
| Rooted in binary assumptions                                                              |                                                                                     |                                                                                     |
| Systemic oppression rooted in essentialist, binary assumptions                              | Participant 2 demonstrated how the theme of “not trans enough” played out frequently in the context of interactions with health care providers | Participant 2 demonstrated how the theme of “not trans enough” played out frequently in the context of interactions with health care providers |
| Pressure to present as “trans enough” by way of essentialist standards to be deemed valid and/or access appropriate health care generates fear, frustration, and anticipated threat | Participant 3 exemplified the idea of “not trans enough,” and binary reification in medical model. Medical interventions are specified as one potential aspect of transition | Participant 3 exemplified the idea of “not trans enough,” and binary reification in medical model. Medical interventions are specified as one potential aspect of transition |
| Medical intervention assumed to define transitioning process; however, interventions are only one potential facet | Participant 11 reflected on essentialist, binary roots in the medical model and gatekeeping | Participant 11 reflected on essentialist, binary roots in the medical model and gatekeeping |
| Participant 7 offered reflections regarding the historical roots of gatekeeping and the invalidation of transmasculine identities | Participant 7 offered reflections regarding the historical roots of gatekeeping and the invalidation of transmasculine identities | Participant 7 offered reflections regarding the historical roots of gatekeeping and the invalidation of transmasculine identities |
| Participant 4 specified medical as one aspect of transition, and demonstrated how “not trans enough” plays out within transgender communities | Participant 4 specified medical as one aspect of transition, and demonstrated how “not trans enough” plays out within transgender communities | Participant 4 specified medical as one aspect of transition, and demonstrated how “not trans enough” plays out within transgender communities |
| Participant 5 pointed to systemic oppression when navigating cisgender frameworks and the necessity of carving out TGD-relevant frameworks | Participant 5 pointed to systemic oppression when navigating cisgender frameworks and the necessity of carving out TGD-relevant frameworks | Participant 5 pointed to systemic oppression when navigating cisgender frameworks and the necessity of carving out TGD-relevant frameworks |
| Participant 8 gave practical examples of systemic oppression (e.g., binary only options on medical forms), representing a large misalignment between the current health care system and TGD well-being | Participant 8 gave practical examples of systemic oppression (e.g., binary only options on medical forms), representing a large misalignment between the current health care system and TGD well-being | Participant 8 gave practical examples of systemic oppression (e.g., binary only options on medical forms), representing a large misalignment between the current health care system and TGD well-being |
| Participant 10 specified medical facets as one part of transition, referring to in-group and out-group pressures to conform to binary expectations | Participant 10 specified medical facets as one part of transition, referring to in-group and out-group pressures to conform to binary expectations | Participant 10 specified medical facets as one part of transition, referring to in-group and out-group pressures to conform to binary expectations |

TGD, transgender and gender diverse.

revised standards of care, participants reported being “forced” to accept a diagnosis, with practitioners wielding “gatekeeping” power to withhold care. Notably, while the applied effects of gatekeeping emerged in this subtheme, thematic roots of gatekeeping as inextricably tied to essentialist assumptions are captured in the previous subtheme (Table 4).

Subtheme 3: Recommendations to improve health care

Participants offered practical suggestions for providers. Foremost, participants wanted to trust, and urged providers to listen and challenge personal biases. Providers would garner trust by informing themselves rather than placing that onus on the individual in their care.
Table 4. Perspectives on Health Care

| Subtheme 2: Consequences of medicalizing gender (i.e., gender as a diagnosis) | Phenomenological interpretations | Participant quotes |
|---|---|---|
| DSM = historical stigma Applied consequences of Gatekeeping vs. Informed Consent models of care Essentialist, binary medical model limits ability to self-actualize, hence, limits well-being Essentialist assumptions giving rise to pathology; both have harmful consequences (e.g., internalized oppression, fear, and apprehension/ avoidance to seek health care) Forced to accept stigmatizing diagnosis to access appropriate care | Participant 7 reflected on the implications of changes to DSM diagnoses over time, and oppression rooted in the medicalization of TGD identities and embodiment | The whole system is really complicated. I don’t think it should be listed as anything honestly. I do think it is an improvement over gender identity disorder being listed as a mental disorder. Now, where it’s gender dysphoria, it has less of a connotation of someone being mentally ill. Rather, they have something that exists and it can be treated if they choose…  But I am super against the medicalization of trans bodies, and trans identities, which I still think… the idea of gender dysphoria in the medical setting is really limiting, and it also allows doctors to keep resources from trans people… I am also liking how informed consent is a thing now, which I didn’t realize until after I had started my [medico-legal] transition. But the gatekeeping model where [they] have to know if you are mentally ill or not before you can start testosterone… where at some places they’re like, ‘You are an adult, here is what it does to your body, feel free to take this medication and keep it monitored.’ So, I think that all medical stuff related to transness is bad [laughs]. It’s really limiting. We want to popularize the term “Gender Euphoria” cuz you know I feel the gender dysphoria in my body, but then there’s internalized trans phobia that society has taught me. Yeah. It’s hard because I have gender identity disorder on my diagnoses because it has to be. I mean, I feel gender dysphoria, but not every trans person does. So, I don’t think it should be pathologized, I don’t think it’s an inaccurate way to describe me [laughs] but it’s not an inaccurate way to describe all trans people or even trans people who want hormones or medical transition. And I think there is no reason why queer identity should be in the DSM. We should have learned this lesson already. What makes me mentally ill is hormones or medical transition. And I think there is no reason why queer identity should be in the DSM. We should have learned this lesson already. What makes me mentally ill is not that I’m trans! [laughs] |
| DSM = historical stigma Applied consequences of Gatekeeping vs. Informed Consent models of care Essentialist, binary medical model limits ability to self-actualize, hence, limits well-being Essentialist assumptions giving rise to pathology; both have harmful consequences (e.g., internalized oppression, fear, and apprehension/ avoidance to seek health care) Forced to accept stigmatizing diagnosis to access appropriate care | Participant 5 illustrated how essentialism and pathology contribute to internalized hatred, and how extra work is needed to reclaim identity and live authentically (self-actualize)—both are core to well-being | Participant 5 illustrated how essentialism and pathology contribute to internalized hatred, and how extra work is needed to reclaim identity and live authentically (self-actualize)—both are core to well-being |
| DSM = historical stigma Applied consequences of Gatekeeping vs. Informed Consent models of care Essentialist, binary medical model limits ability to self-actualize, hence, limits well-being Essentialist assumptions giving rise to pathology; both have harmful consequences (e.g., internalized oppression, fear, and apprehension/ avoidance to seek health care) Forced to accept stigmatizing diagnosis to access appropriate care | Participant 6 added a critical aspect of gender as a diagnosis as it pertains to people with multiple marginalized identities | Participant 6 added a critical aspect of gender as a diagnosis as it pertains to people with multiple marginalized identities |
| DSM = historical stigma Applied consequences of Gatekeeping vs. Informed Consent models of care Essentialist, binary medical model limits ability to self-actualize, hence, limits well-being Essentialist assumptions giving rise to pathology; both have harmful consequences (e.g., internalized oppression, fear, and apprehension/ avoidance to seek health care) Forced to accept stigmatizing diagnosis to access appropriate care | Participants 8 offered insight through personal experiences in gatekeeping and incompetent provider care | Participants 8 offered insight through personal experiences in gatekeeping and incompetent provider care |

(continued)
One suggestion to facilitate self-guided learning included active immersion in TGD communities, and conducting affirmative research in multiple fields of study (e.g., endocrinology, public health, mental health, neuropsychology, and primary care). Interestingly, participants commented that binary constructs also harm cisgender people, restricting variation in identity and expression, and suggested approaching topics of transmasculinity and TGD health with the same respect, curiosity, and fervor as any scientific inquiry. Thus, continual self-reflection, developing TGD-centric frameworks, and challenging socialized biases were described as essential to competent research and practice.

Inclusive clinical forms and environmental cues were important, including diverse décor, competent front-line staff, and witnessing an array of practitioner identities reflecting those of participants. Language was named as a significant catalyst for changing or maintaining the status quo. Participants offered suggestions to expand language, thereby social constructions. For example, abandon binary forced-choice options (e.g., boxes for male/female), add space for pronouns in use, and/or include write-in options for identities in clinical and research demographics (Tables 5 and 6).

Participants highly valued positive patient–provider interactions, which included the following: active listening, demonstrating competencies in TGD health, using correct name and pronouns, and welcoming spaces. Informed providers understood limitations and advocated for change in TGD health care. They were knowledgeable about informed consent versus gatekeeping models, and did not pathologize identity. They listened, rather than pushing a specific trajectory or treatment plan, and did not assume TGD identity as the core of presenting concerns. In fact, informed providers understood transmasculine identity as an individualized process and a source of immense resilience and strength.
Table 5. Perspectives on Health Care

| Subtheme characteristics | Phenomenological interpretations | Participant quotes |
|--------------------------|----------------------------------|-------------------|
| Providers not informed: physically and emotionally taxing for participants Challenge systemic oppression (e.g., binary options only on forms, outdated language or practices, need for facilities to be inclusive and welcoming) Societal expectations and provider bias: • toward transitioning (socially and medically) • assessment, presenting concerns, and treatment planning Providers need to listen, validate, and understand TGD people as both vulnerable and resilient. Transmasculine identity is not the core of distress, rather external stressors Transmasculine identity as a source of resilience (e.g., “gender euphoria”) Explore bias and consequences of binary and medicalization Positive patient-provider experiences can increase levels of safety, trust, validation, and access to competent care, thus reducing disparities | Participant 1 described attributes of a good mental health therapist Participant 5 asserted the critical need for providers to understand TGD people as a vulnerable population, and offered practical recommendations (e.g., explore internal bias, increase positive TGD visibility, and inclusive restrooms) to remedy health disparities Participant 3 shared negative experiences of being misdiagnosed, exemplified the added burden of having to inform practitioners, and offered applied examples of how to reduce disparities in health care provision. | A good therapist is knowledgeable; wise. If they’re young, wise for their years. Experienced. Has connections with all sorts of people so that they have a wider view of who they’re reaching. Um, and they’re not afraid to ask questions. One that’s professional and doesn’t breach certain boundaries that… oh oh oh… and at the very beginning they talk with you about boundaries of what you are expecting, of what they can do. You need to know trans 101, because trans people are a really vulnerable population. There are a lot of young trans mentally ill people who need services where you guys tend to [mess] up. But I’ll just be nice about that last part. I think that internal bias is something mental health providers need to deal with because I’m sure there are plenty of mental health providers who are thinking to themselves, like, trans people are inherently unstable or poly relationships are inherently unstable or gay people are promiscuous… providers need to deal with whatever biases they are holding. They need to make their facilities tangibly more like welcoming and comfortable… put up a cheesy poster about how you accept gender diversity or something in your waiting room! Put some Out magazines in your waiting room or configure facilities so that people have gender-neutral bathrooms. The way that we culturally made changes for disabled accessibility, I think we need to make those changes for trans accessibility. [Providers] would ask me about myself and about my ex, and when I described [us], I used they/them pronouns. [Providers] were getting so confused. They thought I had dissociative identity disorder… Yeah, if I have to teach you about who I am and how I work then you’re probably not the right psychiatrist for me… because you get to talking about trans stuff with them, and you truly feel like you’re a little insane or something. You think maybe there is no one else like me, or maybe there are people out there like me, but they also have a crazy brain disease. That’s kind of how I felt there. It’s always a learning experience even when you have your degree. As medical folks know, there’s new diseases being found, there’s different types of people out there. There’s new genders out there that you didn’t realize were there before, but it’s been around for quite a while. So just brushing up on that, and not thinking of it as something that’s “new age.” Just be more respectful. Medical forms… have an option to put “other.” If someone is trans or not… that’s [being informed] actually a big deal. For example, I have a lot of chest pain because I wear very tight sports bras. I never thought of it, and it was my chiropractor who said my back was messed up. She was like, “Do you do any weird stuff with your back?” It’s always my middle back, and I said I wear tight sports bras, and she asked why I would do that. I said to make my chest flatter. Then it was this really awkward thing. But, if you’re trans and binding all the time, it is really bad for your back. So, having someone in the medical field talk about safe ways to feel better about yourself, that would be really nice… There is such a benefit to knowing someone is trans. My first doctor described it in a way that I really loved. He said that being trans is not an illness, but it’s still something that, for some people, can benefit from medical intervention… similar to a pregnancy. You’re not sick if you’re pregnant, but you still might benefit from accessing medical care. I think that I really benefited from accessing medical care. I don’t plan to have any surgeries currently, but I might change my mind. I know when I came out as genderqueer, people were asking, ‘Are you going to start hormones? Are you going to modify your body?’ I was like, ‘Not right now, I’ll decide later.’ It’s not even what I want them to know, it’s that I want them to care enough to look for the resources to know. Because there is so much information out there on how to support trans people, and how medical transition works. There are so many articles. I’ve done a lot of research on how teachers can be inclusive, medical practitioners can be inclusive, and it’s like people don’t care enough to look up how to do that. They don’t care enough to be educated. So I don’t even think it’s a lack of information, I think it’s a lack of giving a shit about being supportive of trans people. Because I’ve had to go to my doctor and be like, ‘I bind, I know that something is wrong, and I need you to fix it.’ They’re like, ‘Well, we’ve never had a trans person, we don’t know what that is.’ I have had to educate them… Google my own symptoms and be like: ‘Other trans men are experiencing this, and this is something I think I have.’ But I’m not a doctor; they are a doctor! Yeah, they need to look to other practitioners who are knowledgeable and give a shit about being inclusive. I forget the statistic but, from the U.S. Trans survey in 2015, a really high percentage of trans individuals don’t even seek medical care because they don’t want to be disrespected, or they don’t want to have to teach their own doctors… that is ridiculous! |

(continued)
Table 5. (Continued)

| Subtheme characteristics                                                                 | Phenomenological interpretations                                                                 | Participant quotes                                                                                                                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Positive patient–provider experiences can increase levels of safety, trust, validation, and access to competent care, thus reducing disparities | Participant 8 remarked on the bias in mental health care that many presenting concerns are directly related to, and a product of, transmasculine identity | I don’t want it to be as big of a deal in therapy … like every single time I go to the therapist, they’re like, ‘Okay, so you’re transgender…’ and then they take every single issue that I have and frame it around my gender identity, when that’s not the case. My gender doesn’t make me depressed or anxious. The problem is the way that other people are. There’s nothing wrong with me. I don’t need therapy for being transgender. I need therapy for depression and anxiety. I think a lot of the way therapists are taught is that since transgender people have a higher rate of depression and anxiety and other mental health issues, people see it as the cause of those, and that’s not the case. It’s just like any other form of oppression, or bullying, or any of that. Not productive to your profession to frame it as the issue… Instead of making someone’s gender identity the problem, you can make other people the problem… instead of making my gender identity the problem instead of how other people treat me. They make it so much about, ‘Oh, how do you identify? How is your transition going?’ Instead of like, ‘How are you feeling?’ It’s not about transitioning, or being trans. It’s about how I feel. I’d say starting something like they/them pronouns. Having a different option than just male or female, maybe just write in what your sex is. I don’t know. Just having a certain qualifier where I can put down, “Yes, my birth sex is female. For the most part I’m female, but I’m also male, but I don’t have any breasts, and I’m also taking testosterone.” Because it can be very confusing if somebody marks “man” on there, and they are a female bodied person. It can be confusing for medical reasons, so I think definitely having options for not only medical documents but for any type of document that would want that kind of demographic knowledge. I think it’s pretty important. Well, I was paying an arm and a leg before. Yeah, I was going to this place where it was $200 every few months for a blood test. Then I started going to this new place where they have trans doctors there, it’s like a queer office, and they only charge you 60 bucks and it’s freaking awesome. It’s like a clinic. Like a trans clinic. It’s really awesome. The best thing you can do is just listen, as far as therapists, and medical practitioners, too… because I’ve dealt with this. Not every transition is the same, and people cannot compare theirs. I had a doctor who was a trans woman, and she was terrible because she kept trying to compare our transitions and wanted me to do certain things because of it, and personally that’s wrong. People are different and react to things differently. As far as therapists, they just need to listen. They need to understand that they don’t know anything. The trans person that is in therapy knows more about their transitioning than that therapist does, most likely, because they live it they experience it. As much as a therapist wants to try, they will never know how it feels, so they just have to listen and accept what that person is saying. Yeah… we’re limited by the language that we’re using, you know, and we know that the language that we choose impacts how we think about things. It’s not not like those two things can be separated from each other, so I think we do need to open up language significantly because everything is gendered in the binary right now, and it’s not accurate or authentic… and it does harm to people who don’t fall into it that. And it does harm to people who even do fall into that. But I’m really sick of every trans narrative being negative, and doom and gloom. It’s like, here’s a Buzz Feed article of trans people living in gutters. How about no. You know? Let’s create a wider narrative of trans people. Like, I’m trans and I’m working in the field that I love and the way that I express my gender to the world makes me feel gender euphoria because I’m able to be authentic… being authentic makes you feel good about yourself. It makes you feel happy… the opposite of dysphoric. So I want us to latch onto those things. Well, it [trans masculine identity] challenges the idea of gender that people have been given since literally the day they were born. It kind of throws everything about gender out the window, and people don’t like new things. They don’t like their ideas challenged. It’s like, in first grade when you learned about multiplication, and they had to explain it to you using addition because addition isn’t scary. You’ve been learning about this for, like a year now, but then you go into multiplication and it’s like, “Oh my God! What is this?” But really, it’s not that bad. As soon as people start understanding it, it’s not that bad. |
| Providers not informed: physically and emotionally taxing for participants                                                                 | Participant 12 pointed to accessibility to trans affirmative care. In addition, his account demonstrated how misinformation is not limited to cisgender providers. Finally, Participant 12 takes a humanistic view on what it means to be a good therapist | Providers need to listen, validate, and understand TGD people as both vulnerable and resilient. Transmasculine identity is not the core of distress, rather external stressors. Transmasculine identity as a source of resilience (e.g., “gender euphoria”) |
| Challenge systemic oppression (e.g., binary options only on forms, outdated language or practices, and need for facilities to be inclusive and welcoming) | Participant 5 remarked on the power of language in maintaining or challenging oppression; expanding language will be liberating for all gender identities. In addition, expanding the narrative on TGD identities and increasing positive visibility will result in more accurate representations of TGD people’s lives and resiliencies. | Participants not informed: physically and emotionally taxing for participants Challenge systemic oppression (e.g., binary options only on forms, outdated language or practices, and need for facilities to be inclusive and welcoming) Societal expectations and provider bias: • toward transitioning (socially and medically) • assessment, presenting concerns, and treatment planning Providers need to listen, validate, and understand TGD people as both vulnerable and resilient. Transmasculine identity is not the core of distress, rather external stressors. Transmasculine identity as a source of resilience (e.g., “gender euphoria”) Explore bias and consequences of binary and medicalization Positive patient–provider experiences can increase levels of safety, trust, validation, and access to competent care, thus reducing disparities |
Dysphoria (DSM-5, 2013). Revisions represented a shift in ideology focused on treating psychological distress rather than labeling TGD identity a disorder. However, the individual and their embodiment remain the crux of distress. Notably, our data indicated that gender-related psychological distress stemmed predominantly from external sources of transphobia and cissexism. Finally, the current diagnosis acknowledges not all transgender individuals experience dysphoria, but presumes medical intervention is the next step for those who do, and diagnostic language reifies an essentialist binary (e.g., diagnostic criterion: “A strong desire to be of the other gender”).

Overall, standards of care have progressed, as evidenced by those set forth by WPATH. However, gatekeeping persists. For example, as noted, WPATH included a revision stipulating that individuals 18 years of age and older should be granted access to care based on informed consent. However, providers are not mandated to uphold these practices, and maintain great power in governing TGD identities. In addition, despite revisions to the DSM-5 and ICD-11, reframing systemic policies, cultural norms, and health professionals’ perspectives will be a process that requires insight and time.

Tangible inlets for reducing health disparities

Participants’ negative experiences could be understood through the Minority Stress Model, which Meyer characterized as (1) unique and additive, (2) chronic, and (3) socially devised/maintained. Marginalized people must continually adjust to additive and pervasive stressors not experienced by nonstigmatized individuals. Embedded in a sociocultural context, the stress is chronic and unrelenting, and may lead to negative biopsychosocial health outcomes. Finally, marginalization and resultant stress are perpetuated through socially derived institutions and systems (e.g., health care) outside of one’s control, devised to maintain existing power hierarchies.

In addition, the Weathering Hypothesis proposes that accumulated burden from confronting multiple,
on-going psychosocial stressors manifests as accelerated aging. The related theories of minority stress and weathering have been independently tied to adverse health effects (e.g., allostatic load, diabetes, cardiovascular disease, depression, and post-traumatic stress disorder) in people with marginalized identities. Researchers are beginning to include TGD individuals in studies exploring the mental and physical health effects of minority stress and weathering.

Our data illustrate how minority stressors and weathering ensue through patient–provider interactions, offering tangible inlets to reduce health disparities. For example, consistent with NTDS findings, our participants described having to repeatedly educate providers steeped in ciscentric, binary views. They described this process as physically and emotionally taxing, exemplifying minority stress and potentially invoking the weathering process. Despite pleas for competent health care, essentialism in the medical system reflects an inherent bias toward caring for cisgender individuals, prompting TGD individuals to avoid health care rather than risk invalidating oppressive and unsafe interactions.

In addition, marginalization and subsequent minority stressors and weathering processes are perpetuated through medicalizing gender and gatekeeping practices (i.e., requirement of a pathological, stigmatizing diagnosis and multiple letters of support to access care). Ciscentric and essentialist reference points in the medical approach link interventions to diseases and disorders. Perpetuate social expectations that cisgender identity is the normal and valid standard, and serve as bedrock for participants’ fears around being perceived “not trans enough.” For example, Benjamin was among the first physicians to offer hormonal and surgical options for trans-identified people. However, consistent with the medical zeitgeist, he labeled “true” trans people as those who desire medical intervention to “align” their physical bodies with their gender identity.

This message persists today, as our participants experienced repeated stressors and unrelenting pressure to align with cisgender conceptions of male/masculine to appease gatekeepers. For our transmasculine participants, “not trans enough” centered around expectations to conform to socially constructed standards of masculinity to be deemed valid. Moreover, participants reported a double standard in following prescribed cisgender trajectories. For example, feminine cisgender men may be targets for discrimination; however, their gender identity and sex are not questioned as is common with transmasculine people who demonstrate similar qualities.

Entwined with the Benjamin standards, “not trans enough” is steeped in essentialism and perpetuated through authoritative frameworks, such as multiple iterations of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Davis et al characterized the Institute of Medicine’s influence in creating and disseminating ideologies around sex, gender, and sexuality as such, “… they not only perpetuate but produce the notion that a healthy body is identifiably male or female, masculine or feminine, and heterosexual.”

This creates tension, as providers have the power to bestow sex and gender, as well as reify the status quo. In sum, the consequences of essentialism in medicine are fundamental to participants’ negative experiences, resulting in minority stress, inaccurate diagnostic assessment and treatment, increased vulnerability, distrust, and avoidance of health care. Thus, it is imperative that practitioners and researchers examine socialized biases. In doing so, we have power to minimize deleterious effects of compounding distal minority stressors and weathering processes on TGD people, and maximize outcomes in TGD health.

More than half of participants described burdensome nuances of minority stress associated with viewing TGD identities as a pathology, and subsequent gatekeeping practices. To elaborate, letters from physicians and psychologists are often required to begin legal processes of amending identity documents (e.g., driver’s license, and passport). Many U.S. states require a surgeon’s letter to amend assigned sex on birth certificates. In other words, some form of binary-based surgical intervention must be performed, regardless of individual preferences or socioeconomic access. Interestingly, the process of gatekeeping may inflate or misrepresent rates of TGD individuals seeking psychotherapy, their presenting concerns, and rates of gender dysphoria diagnoses.

In addition, some participants who desired medical intervention(s) sidestepped gatekeeping (i.e., adapting to minority stress) by finding clinics offering services based on informed consent. Participants understood this access as a privilege, closely tied to other facets of identity (e.g., socioeconomic status, race, and geographic location). While participants were not specifically asked about their level of access to health insurance coverage, disclosures were intertwined in many participant responses. Overall, participants demonstrated a high level of insight and awareness regarding privileges they benefited from, including access to health insurance and/or any degree of gender-related service coverage. However, despite most participants having access to health care,
most expressed added burdens, such as facing discrimination, while having to navigate a complicated system on their own, or repeatedly educating providers around gender identity and sex. For this reason, trust may be difficult to establish in a variety of settings, including educational settings that frequently rotate providers (e.g., hospital residents and interns).

Practitioners’ assumptions and pathology-based framework contribute to an essentialist, gatekeeping model that imposes minority stressors detrimental to TGD health. However, consistent with the literature, our participants challenged pathological notions of TGD identity by reporting ways transmasculine identity serves as a source of pride, well-being, and resilience that can buffer the negative effects of minority stress and weathering. Moreover, participants rejected the idea that one must be dysphoric to benefit from medical intervention. As one participant explained, one who is “euphoric” may also desire medical options. Participants challenged the “one and done” conceptualization of transitioning, explaining that transition is a multifaceted psychosocial developmental process that may or may not include any number of medical interventions.

In response, TGD health experts consistently advocate for nonpathological frameworks to conceptualize gender identity development, evidence-based care, and access to affirmative care, including informed consent. Revisions to the ICD will inevitably bring changes on an international scope, but the directions of change have yet to be seen, and shifting the landscape to a non-pathological framework will take time.

In the meantime, providers can take practical steps to reduce the significant and cumulative burden of minority stress, as reported by participants in this study (Tables 5 and 6). Providers can acknowledge and challenge socialized biases, educate themselves, immerse themselves, and work with TGD communities to advocate for change in research, practice, and policy. Providers can be transparent with patients, acknowledging strengths and limitations of current systems. Providers can be knowledgeable in TGD health research, pass this information along to patients, and collaboratively support them as they make informed decisions around their health care.

Strengths and limitations
Strengths of IPA methodology included the ability to develop research questions relevant to transmasculine health, and recruit participants accordingly. The idio-
for the courageous and resilient participants who offered their time and trust to advance research benefitting TGD health today, and in generations to come. This is GRECC article number 002-2020.

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References

1. Flores A, Herman J, Gates G, Brown T. How Many Adults Identify As Transgender in the United States? The Williams Institute. Los Angeles, CA: UCLA, 2016.
2. Nagoshi JL, Bruzzi SL, Terrell HK. Deconstructing the complex perceptions of gender roles, gender identity, and sexual orientation among transgender individuals. Fem Psychol. 2012;22:405–422.
3. Elaison MJ, Schoppe R. Shifting sands or solid foundation? Lesbian, gay, bisexual, and transgender identity formation. In: Meyer IH, Northridge ME, eds. The health of sexual minorities. Boston, MA: Springer US, 2007. pp. 3–26.
4. Morton TA, Postmes T, Haslam SA, Hornsey MJ. Theorizing gender in the face of social change: is there anything essential about essentialism? J Pers Soc Psychol. 2009;96:653–664.
5. Grant JM, Mottet LA, Tanis J, et al. National Transgender Discrimination Survey Report on Health and Health Care. National Center for Transgender Equality and National Gay and Lesbian Task Force, Washington, DC: 2010. pp. 1–23.
6. Poteat T, German D, Kerrigan D. Managing uncertainty: a grounded theory of stigma in transgender health care encounters. Soc Sci Med. 2013;84:22–29.
7. Eze C. Deconstructing the body: transgender and intersex identities and sex discrimination-the need for strict scrutiny. Colum J Gender L. 2011;20:141.
8. Davis G, Dewey, M., Murphy, E. Giving Sex: deconstructing intersex and trans medicalization practices. Gender Soc. 2016;30:490–514.
9. Meyer IH. Prejudice, social stress, and mental health in Lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychol Bull. 2003;129:674–697.
10. Lick DJ, Durso LE, Johnson KL. Minority stress and physical health among sexual minorities. Perspect Psychol Sci. 2013;8:521–548.
11. Geronimus AT. The weathering hypothesis and the health of African-American women and infants: evidence and speculations. Ethn Dis. 1992;2:2207–2221.
12. Dragon CN, Guerino P, Ewald E, Laffan AM. Transgender medicare beneficiaries and chronic conditions: exploring fee-for-service claims data. LGBT Health. 2017;4:404–411.
13. Fredriksen-Goldsen KI, Cook-Daniels L, Kim H-J, et al. Physical and mental health of transgender older adults: an at-risk and underserved population. Gerontologist. 2013:54:488–500.
14. Hoy-Ellis CP, Fredriksen-Goldsen KI. Depression among transgender older adults: general and minority stress. Am J Community Psychol. 2017:59:295–305.
15. Coleman E, Bockting W, Botzer M, et al. Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. Int J Transgend. 2012;13:165–232.
16. World Health Organization (WHO). ICD-11 for Mortality and Morbidity Statistics 2019. Available at https://icd.who.int/browse11/l-m/en (accessed November 3, 2019).
17. World Health Organization (WHO). WHO/Europe Brief—Transgender Health in the Context of ICD-11. 2019 Available at: http://euro.who.int/en/health-topics/health-determinants/gender/gender-defintions/who-europe-brief-transgender-health-in-the-context-of-icd-11 (November 11, 2019).
18. BBC News. Transgender No Longer Recognised As ‘Disorder’ by WHO 2019. Available at: https://www.bbc.com/news/health-48448804 (November 11, 2019).
19. Drescher J. Gender Diagnoses and ICD-11: Theorizing transgender health care encounters. Soc Sci Med. 2013;84:22–29.
20. Smith JA, Flowers P, Larkin MH. Interpretative Phenomenological Analysis: Theory, Method and Research. Los Angeles, CA: SAGE, 2009.
21. Smith JA, Osborn M. Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. Br J Pain. 2015;9:41–42.
22. Pietkiewicz I, Smith JA. A practical guide to using interpretative phenomenological analysis in qualitative research psychology. Psychol J. 2014;2:207–14.
23. Creswell J. Qualitative Inquiry and Research Design: Choosing Among Five Traditions. Thousand Oaks, CA: Sage, 1998. p. xx.
24. Cañatáreda C. Developing gender: the medical treatment of transgender young people. Soc Sci Med. 2015;143(C):262–270.
25. Denny D. The politics of diagnosis and a diagnosis of politics: the university-affiliated gender clinics, and how they failed to meet the needs of transgender people. Chrysalis Q. 1992;19–20.
26. Drescher J. Queer diagnoses: parallels and contrasts in the history of homosexuality, gender variance, and the diagnostic and statistical manual. Arch Sex Behav. 2010;39:427–460.
27. Rubin H. The Logic of Treatment. New York: Routledge, 2006.
28. Schulz SL. The informed consent model of transgender care: an alternative to the diagnosis of gender dysphoria. J Hum Psychol. 2018;58:72–92.
29. Stryker S. Transgender History. Berkeley, CA: Seal Press, 2008.
30. Stryker S. Transgender History: The Roots of Today’s Revolution. Boulder, CO: Seal Press, 2017.
31. Johnson AH. Normative accountability: how the medical model influences transgender identities and experiences. Sociol Compass. 2015;9:803–813.
32. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM-III). Washington, DC: American Psychiatric Association, 1980.
33. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM-V). American Psychiatric Pub., Washington, DC: 2013.
34. Rood BA, Reisner SL, Surace FL, et al. Expecting rejection: understanding the minority stress experiences of transgender and gender-nonconforming individuals. Transgend Health. 2016;1:151–164.
35. Bockting WO, Miner MH, Romine RES, et al. Stigma, mental health, and resilience in an online sample of the US transgender population. Am J Public Health. 2013;103:943–951.
36. Frost DM, Lehavot K, Meyer IH. Minority stress and physical health among sexual minority individuals. J Behav Med. 2015;38:1–8.
37. Lehavot K, Walters KL, Simoni JM. Abuse, mastery, and health among lesbian, bisexual, and two-spirit American Indian and Alaska Native women. Cultur Divers Ethnic Minority Psychol. 2009;15:275–284.
38. Pols PA. Stress and health: major findings and policy implications. J Health Soc Behav 2010;51(1_Suppl):S41–S53.
39. Steptoe A, Marmot M. Burden of psychosocial adversity and vulnerability in middle age: associations with biobehavioral risk factors and quality of life. Psychosom Med. 2003;65:1029–1037.
40. Trexel WM, Matthews KA, Bromberger JT, Sutton-Tyrrell K. Chronic stress burden, discrimination, and subclinical carotid artery disease in African American and Caucasian women. Health Psychol. 2003;22:300.
41. Williamson TJ, Mahmood Z, Kuhn TP, Thames AD. Differential relationships between social adversity and depressive symptoms by HIV status and racial/ethnic identity. Health Psychol. 2017;36:133.
42. Reisner SL, White Hughto JM, Gamarle KE, et al. Discriminatory experiences associated with posttraumatic stress disorder symptoms among transgender adults. J Couns Psychol. 2016;63:309.
43. Mays VM, Juster R-P, Williamson TJ, et al. Chronic physiologic effects of stress among Lesbian, gay, and bisexual adults: results from the National Health and Nutrition Examination Survey. Psychosom Med. 2018;80:551–563.
44. Weinhardt LS, Stevens P, Xie H, et al. Transgender and gender nonconforming youths’ public facilities use and psychological well-being: a mixed-method study. Transgend Health. 2017;2:140–150.
45. Cavanaugh T, Hopwood R, Lambert C. Informed consent in the medical care of transgender and gender-nonconforming patients. AMA J Ethics. 2016;18:1147–1155.
46. Johnson AH. Transnormativity: a new concept and its validation through documentary film about transgender men. Soc Inq. 2016;86:465–491.
47. Benjamin H. The transsexual phenomenon. Trans N Y Acad Sci. 1967;29:428–430.
48. Koenig JL. Distributive consequences of the medical model. Harvard Civil Rights Civil Liberties Law Rev. 2011;46:619–647.
49. Budge SL. Psychotherapists as gatekeepers: an evidence-based case study highlighting the role and process of letter writing for transgender clients. Psychotherapy. 2015;52:287.
50. Johnson AH. Beyond inclusion: thinking toward a transfeminist methodology at the center: feminism. Soc Sci Knowl. 2015;20:21–41.
51. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Washington, DC: American Psychiatric Association, 1994.
52. Bockting W, Robinson B, Benner A, Scheltema K. Patient satisfaction with transgender health services. J Sex Marital Ther. 2004;30:277–294.
53. Riggle ED, Rostosky SS, McCants LE, Pascale-Hague D. The positive aspects of a transgender self-identification. Psychol Sex. 2011;2:147–158.

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Abbreviations Used

IPA = Interpretive Phenomenological Analysis
NTDS = National Transgender Discrimination Survey
TGD = Transgender and Gender Diverse
WHO = World Health Organization
WPATH = World Professional Association for Transgender Health