Becoming Visible: A Qualitative Analysis of Female to Male Transsexuals' Coming Out Experiences

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Dissertation Approval

This is to certify that the dissertation presented to us by Emily R. Chernicoff on the 16th day of December 2002, in partial fulfillment of the requirements for the Degree of Psychology, has been examined and is accepted in both scholarship and literary quality.

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Abstract
This research explores the coming-out processes of 11 transgendered individuals who underwent female-to-male sex reassignment. Its purpose is to expand upon the cultural literacy of clinicians called upon to support transgendered clients who present with the intent to transition. The thesis is predicated on the argument that the differently-gendered constitute an understudied and discrete cultural minority, similar to ethnic, racial and sexual minorities, for whom identity formation is similarly impacted by socio-cultural influences. Qualitative content analysis of transcribed semi-structured interviews was conducted. Phase analysis was found to parallel both Cass’s 1979 stage-model theory of sexual minority identity formation, and Devor’s 2001 stage model of transsexual identity development, with minor variation. Grounded theory building revealed a 4-part coming-out process: (a) an Intrapsychic phase, (b) an Interpersonal/Interactive phase, (c) an Arrival phase, and (d) an Integrative phase which, by report, uniformly resulted in a heightened quality of life for all participants. The author concludes that the overridinglly positive outcomes are attributable to early parent-child attachment and the increase in ego strength conferred by sex and gender congruency, suggesting avenues for future investigation.
“Every man is the builder of a temple, called his body, to the God he worships, after a style purely his own, nor can he get off by hammering marble instead. We are all sculptors and painters, and our material is our own flesh and blood and bones.”

Henry David Thoreau
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Chapter 1
Introduction

Statement of the Problem

It is often necessary to afford ubiquitous scientific attention and resources to a field of research in order to create a change that is powerful enough to improve society. Such a paradigm shift occurred in 1994, making possible a heightened quality of life for hundreds of thousands of individuals who heretofore were clinically stigmatized as deviant members of society. Following decades of heated debate, and as the result of a significant literature base, identity formation for gays and lesbians was, for the first time, defined as a normative pathway of development. The American Psychiatric Association finally overturned homosexuality as a pathological classification, by formally eliminating it from the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (1994). The American Psychological Association (APA) swiftly supported the shift. By February of 2000, the Division 44 Taskforce of the APA enacted the first *Code of Ethics for Treating Lesbian, Gay and Bisexual Clients*, thus subsuming sexual minorities within the domain of multicultural studies.

Among these guidelines is the imperative to become sensitized and educated through specialized training regarding the needs of minority groups sharing distinct characteristics. The thrust toward incorporating knowledge of sexual minorities as a
Becoming Visible

Clinical competency within the domain of multicultural literacy is rationalized as follows: Because the identity formation tasks that racial and ethnic minorities must accomplish are similar to those for sexual minorities, and the multicultural counseling skills required for dealing with both are similar, there is, therefore, "a culture" of sexual minorities. Moreover, "...oppression and the results of oppression by the majority culture are very real, with real effects on people's lives, development and careers" (Pope, 1995, p. 301).

However, while the community of mental health professionals has been busy with the process of desensitizing and re-educating itself regarding sexual minorities, there remains a minority population that is invisible: The transgendered. These individuals differ significantly from those who identify as gay, bisexual, and lesbian, in that their minority identity is unrelated to their sexual preference (Denny, 1999). Transgendered people may also self-identify as heterosexual, gay, lesbian, or bisexual and therefore evolve through the intrapsychic, relational and cultural stages of identity formation necessary to acknowledging, accepting and identifying oneself as a sexual minority. However, the major defining characteristic of transgendered individuals is that they psychosocially identify with the gender opposing their biologically determined sex.

One may, for instance, be born with external genitalia and internal organs of a man, but experience oneself as a woman or girl "hidden" within a male body. Conversely, transgendered women are born with all of the external genitalia and internal reproductive organs of a female, yet feel as if they are men "trapped" within a female body (Cromwell, 1999). Awareness of incongruence between one's
sex and gender typically emerges around the age of four (Bradley & Zucker, 1997), producing a developmental trajectory fraught with confusion, and leaving the individual feeling outside of mainstream society. Being transgendered is often described as feeling like an invisible birth defect that the person spends a lifetime attempting to reconcile (W. Moyer, Personal communication). This phenomenon is clinically defined in the *Diagnostic Statistical Manual of Mental Disorders* (1994) as Gender Identity Disorder (GID), and may be diagnosed in childhood, adolescence or adulthood. However, psychiatrists and psychologists have met with minimal success in attempting to ameliorate the distress induced by GID. Consequently, during the later half of the 20th century, unknown numbers of transgendered individuals have prevailed upon the medical community to acquire the feeling of congruence that psychotherapy failed to produce: They have turned to endocrinologists and reconstructive and cosmetic surgeons to rectify the experienced inconsistency between physiology and gender identity. And they turn to mental health professionals to coach them through the complex and arduous physical and emotional changes concomitant with hormone therapy and sex reassignment surgery (Brown & Rounsley, 1996; Denny, 1999; Ettner, 1999; Kessler, 1998).

The Harry Benjamin International Gender Identity Dysphoria Association's Standards of Care Guidelines for the Hormonal and Surgical Sex Reassignment of Gender Dysphoric Persons (2001), have guided many, although not all, transgendered people who choose to become transsexual: fully men or fully women. For most, this dramatic and difficult transition produces an overwhelmingly
reported sense of relief and satisfaction that years of psychotherapy alone could not succeed in producing (Benjamin, 1966; Cohen-Ketteris & van Goozen, 1997; Diamond, 1966; Etter, 1999; Haraldson, 2000; Hoenig, 1995; Lothstein, 1982; Mason Shrock, 1996; Mate-Cole, Freschi & Robin, 1990; Pfaefflin & Junge, 1998; Rachlin, 2001).

Despite being considered members of the gay, bisexual and lesbian community, the transgendered and transsexual community continues to be perceived as an anomaly that is largely ignored, denied or stigmatized by American society. These individuals also beg for the recognition and understanding that the community of sexual minorities has begun to achieve. However, with rare exception, current studies concerning female-to-male and male-to-female transsexuals have been confined to two realms: the medico-surgical literature related to sex reassignment surgery (SRS), and the invisible and marginalized literature written by and for members of the transgendered community. Both bodies of literature evolved as a direct result of John Money's (1955) seminal work wherein, for the first time, the constructs of sex and gender were defined as distinct and separate. While “sex” continued to denote reproductive biology, hormones and external genitalia, “gender” was distinguished as referring to somatic and behavioral criteria regarding how an individual personally and socially, and how one was legally regarded. Since that time, and despite repudiation of Money's ethics later (Colapinto, 2000), formalized gender studies reflecting this distinction have permeated anthropological, sociological, psychiatric and psychological research. Gender study has typically focused on the psychology of men and the
psychology of women (Unger, 2002; Levant, 1999). However, clinical attention and resources have yet to be directed toward the psychosocial dilemmas of the transgendered individual.

**Prevalence**

Although multiple studies of incidence and prevalence of gender variance have been conducted throughout the world, it remains difficult to assess. Sweden's Bureau of Social Welfare Registry conducted a statistical comparison of incidence of transsexualism spanning 1960 to 1992. Rates were found to remain constant over time, and the incidence was equal for men and women (Landen, Walinder & Lundstrum, 1996). A 1993 study in the Netherlands revealed the prevalence of transsexualism by tabulating numbers of patients approved for hormonal and surgical treatment. There the incidence for male-to-females was 1:11,900, and for female-to-male, 1:30,400 (van Gooren & Megens, 1996). Tsoi (1988) found Singapore's ratio as 1:2,900 for male-to-females, and 1:8,300 for female-to-males. Gallarda et al. (1986) assessed French prevalence as anywhere from 1:50,000 to 1:100,000. In Poland and Turkey, the overwhelming majority of individuals applying for sex reassignment surgery were female-to-male. Similarly, in Japan, where the first legal SRS occurred in 1998, 70% of the requests made were from females. Interestingly, gender dysphoria is not an issue for Hindu and Buddhist Southeastern Asians, who believe the condition is a residual manifestation of a previously remembered life (Stevenson, 1977). However, even Islamic nations that
forbid SRS have reportedly had citizens cross continental borders to acquire treatment (Costa-Santos & Madiera, 1996). Ettner (1999) estimates that between 5% and 10% of the United States population has some degree of gender dysphoria. A 1978 estimate of the incidence of transsexualism in the United States was 1:50,000 for males and 1:200,000 for females.

Popular awareness of the existence of transsexuals within the United States appears limited to two cases publicized nearly 50 years apart. In 1952, an American athlete named George Jorganson returned from a journey to Denmark as "Christine," unleashing enormous publicity. Men and women seeking sex reassignment treatment deluged both Jorganson and the Danish medical team. More than 100, or 23% reported requests were from females who wished to become males (Lothstein, 1982). By the 1970s, more than 50 gender identity clinics were operating within the United States; most notably, the Johns Hopkins Gender Clinic. However, a rash of reactive research that was later assessed as politically motivated and methodologically sloppy, resulted in the closing of Hopkins and other clinics by 1980 (Colapinto, 2000; Denny, 1999; Raymond, 1979; Meyer & Reder, 1981).

More recently, an award-winning major motion picture, Boys Don't Cry, recounted the biography of 21-year-old Brandon Teena (nee Tina Brandon) who, as a result of living as a transgendered female-to-male, was viciously raped by two men who eventually murdered him (Konigsberg, 1995; Minkowitz, 1994). Meeting with violence is a common theme in transgendered autobiographies. Accounts of the Brandon Teena story and others portray the transgendered as "false signifiers" who are committing a willful, socially deceitful and criminal act against society.
Becoming Visible (Pagliassotti, 1993). This so-called “deceitful act,” commonly referred to throughout history as “passing,” has been the only safe haven for minorities throughout history. Most notably, light-skinned African Americans sought to secure the privacy of their racial identity and avoid stigmatization by passing as white (Freidli, 1987).

Clearly, the challenge to traditional notions of gender-identity evoke significant cognitive dissonance, emotional discomfort and, at times, behavioral reactivity in both the transgendered individual and all others confronted with this nonconforming presentation of self. The disclosing of one’s identity as transgendered can be assumed to be a daunting prospect, generating intrapsychic, interpersonal and social challenges to all who are impacted. To date, there is a dearth of research designed to educate psychologists about helping transsexual clients manage the challenges inherent in the coming out process.

**Purpose of the Study**

Rebecca Erickson (1995) calls the phenomenological reality of acting consistently with one’s closely held values “authenticity,” or invoking the “true self” (p. 121). It is this “true self” that the transgendered individual seeks to achieve through the process of identity formation commonly called “the act of coming out.” How that is achieved may vary from individual to individual, but there may also be shared, universal experiences.
Four imperatives underscore the importance of expanding the knowledge base of psychologists regarding transsexuality. First and foremost, psychologists are now ethically bound to become culturally literate in multiple areas of diversity (Sue & Sue, 1999). The transgendered community has yet to be formally acknowledged in the psychological literature. Third, according to the current standards of care (2001), a precondition for all transgendered individuals seeking sex reassignment is engagement in psychotherapy. In one of the few studies exploring transsexuals’ experiences of psychotherapy, Rachlin (2001) found that provider experience with gender issues was associated with better rapport, higher patient satisfaction, and greater progress in both personal and growth related issues. Yet, few psychologists are prepared to provide gender-sensitive therapy to this community.

This research therefore seeks to expand on the existing base of psychological knowledge about transgendered individuals by paralleling the course of study originally applied to the gay and lesbian population, in which identifiable events and phases of the coming out process have been found to be predictive of specific problems of living. Its goal is to add to the base of knowledge available to practicing clinicians called upon to counsel and support transgendered clients presenting for therapy by depathologizing normative developmental issues. Specifically explored is gender identity as exemplified through the process of “coming-out” in the context of familial and working relationships.

Unlike gay, bisexual and lesbian individuals, the transgendered who transition to transsexualism do not have the option of not disclosing their authentic identity or to remain “closeted.” The Benjamin Guidelines (2001) recommend that
the candidate engage in a 3-month “Real-Life-Experience” prior to initiating hormone treatment. During this period, the transitioning person is advised to adopt the persona and accoutrements of the desired gender. They are counseled to “live as if” by (a) functioning as a full-time or part-time employee or student, (b) functioning in community-based volunteer activity, (c) acquiring a legal gender-identity-appropriate first name, and (d) providing documentation that persons other than their therapist know that the candidate does function in the desired gender role. According to the HBIGIDA Standards of Care (2001), “…If the candidate prospers in the desired role they are generally confirmed as transsexual” (HBIGIDA Standards of Care, Section IX, 2001). However, the Standards of Care also clearly caution professionals not to “misconstrue the real-life experience as the real life test of the ultimate diagnosis,” further explaining that the discontinuation of the real life-experience does not rule the individual out for candidacy. Given the social climate, the committee recognizes that physical danger or violence is sometimes inherent in living as-if. Living as-if is therefore recommended but not enforced as a requirement for sexual reassignment.

Hormone therapy is typically initiated following successful completion of the test, the effects of which are the gradual, but inevitably overt, development of secondary sexual characteristics. Therefore, unless the candidate chooses to geographically relocate, disengage from all extant relationships, and essentially deny his or her past, the option of closeting, once available if he or she were gay, bisexual or lesbian, is not possible. Disclosure of one’s intentions must be revealed to family, friends and co-workers. This study aims to explore the internal disclosure
process and its impact on the individual in the context of his family and working environment.

Understanding the transsexual experience necessitates an in-depth understanding of the construct of gender and of the processes inherent in the acquisition of gender identity. While these processes vary for homosexual and transsexual development, they are nonetheless mutually grounded in the fundamental theories and principles of social psychology. Social influences, including perception of self and other, fundamental attribution error and impression management have been critical to the understanding of development of gay and lesbian identity formation and consequently must be delineated to appreciate the complexity of the transsexual experience.

There is now a vast literature on the formation of sexual identity for heterosexuals and for homosexuals, which, for homosexuals, is commonly referred to as “the coming-out process to self and others.” However, research into the distinctly different coming-out process for transgendered persons becoming transsexual remains limited. Unexplored areas include committing to a transsexual identity, accessing the medical system, initiating testing, hormone therapy and sex reassignment surgery and disclosing to significant others. This study aims to determine what, if anything, can be extrapolated from the literature on the identity formation of gays and lesbians to that of the female-to-male transsexual, with a focus on the internal and interpersonal dynamics of disclosure of transsexual identity.
Theoretical Background: Foundations in Social Psychology

The Impact of Prejudice, Attribution and Stereotyping on Minority Identity Development

For the transgendered person, the intrapsychic push toward authentically coming out is invariably met by a countering societal force of equal magnitude to conform to social norms of gender. It is at this tumultuous intersection of self and society, at which transgendered individuals striving gender congruence meet with powerful social prejudice in the form of stereotyping.

Cognition, prejudice and stereotyping. The transgendered tend to be prejudicially judged solely on the basis of being members of the “differently gendered.” Fundamental theories of causal attribution, attribution error, and prejudice from the field of social psychology best account for this dynamic phenomenon. A review of relevant theory and research follows in support of the bifurcated social constructionist models representing both self and society.

Prejudice functions as a cognitive schema for processing social information. Comprised of evaluations and beliefs, prejudice emerges when forming impressions and making judgments about others. Simply put, a cognitive schema such as prejudice serves as a mental short-cut to reduce the amount of mental effort necessary (McCrae, Bodenhausen, Milne & Gellen, 1994). However, these heuristic, labor-saving devices become self-confirming, and often lead to wrong conclusions
when consolidated into the cognitive frameworks of stereotypes. In the case of transsexualism, prejudicial stereotype of the person who is transsexual has been predominantly negative.

Acquired through direct and vicarious experience, prejudice and stereotyping are predicated on basic theories of attribution: Kelley’s (1972) “theory of causal attribution,” the theory of “correspondent inference”, and the “fundamental attribution error” (Jones & Davis, 1965). Kelley (1972) found that causal attributions are typically made in two situations: (a) when we are confronted with unexpected events, or (b) when an unpleasant outcome is encountered. In either of these situations we attend to three particular dimensions that lead to the need to attribute a cause: consensus, consistency and distinctiveness. If a high proportion of others have a strong reaction to the situation, then there is consensus. If the same reaction occurs over time, consistency is added to the equation. The extent to which one reacts in the same manner in similar situations or to like stimuli in a distinctive manner is the third and final necessary element for precipitating causal attribution.

According to Jones and Davis’s (1965) theories of correspondent inference and fundamental attribution error, attributions about others are generally based on consideration of behaviors that are freely chosen, and not forced on the actor. Moreover, the greatest attention is likely to be paid to the behaviors of others who are low on the social desirability scale, or who are out of the ordinary. This leads to the fundamental attribution theory, or the tendency to make more positive attributions about members of our own group, and negative attributions about
Thus, negative attributions are ascribed to transgendered and transsexual individuals because they fit all the requirements necessary to elicit attribution errors. They are perceived as anomalies, and they confront the traditionally gendered individual with an unanticipated difference that is experienced as threatening. Additionally, despite current theory citing a combined biopsychosocial basis for transgenderism, the biological bases are ignored by, or unknown to, society-at-large. Consequently, this group of individuals is believed to be freely choosing to be different. Given these fundamental theories, prejudice and stereotyping appear inevitable for the differently gendered.

_Affect, prejudice and stereotyping_. Recent research reveals that prejudice and stereotypical thinking involve not only cognition, but also affect, mood and physical effects on the recipient. In a study conducted by Jussim, Nelson, Manes & Sofflin (1995) participants were asked to rate strangers who were identified as either child abusers or rock musicians on dimensions of creativity and mental illness, identifying feelings and beliefs about the two groups. Subjects were asked to rate each group on dimensions of ambition, intelligence and susceptibility to drug and alcohol dependence. The musicians were rated as significantly more creative and significantly less mentally ill. When the same study was conducted, changing the independent variables to homosexuality and heterosexuality, the results held constant, with the heterosexual group rated as more creative, ambitious, and mentally healthy.
Levy and Langer (1994) found evidence that stereotypical thinking not only shapes social thought, but physiology as well. Based on the premise that premature cognitive commitments to beliefs may be unconsciously and unconditionally made and remain unexamined throughout life, they compared groups of American and Chinese deaf subjects, with American hearing subjects, half young and half old, measuring performance on memory tests. Results revealed that the older Chinese subjects consistently performed significantly better in memory tests than American elderly subjects, suggesting that Chinese beliefs, or cultural commitments to respect and valuing of the wisdom of their aged members actually enhanced their memory, as compared to the American tendency to devalue senior members.

Kessler and McKenna (1978), who specifically examined gender attributions, found that the fundamental schematic attribution is "to see someone as female only if, or when, you cannot see the person as male" (p.158). Simply put, the social schema for "human" is first male, and second, female. It is therefore reasonable to conclude that the cognitive, affective, behavioral and physiological factors come into play, producing anti transgender prejudice and stereotyping.

The first formal psychological studies of prejudice were likely catalyzed by the horrors of "national cleansing" perpetrated by the Nazi regime in World War II. In 1954, Gordon Allport published what is regarded as the seminal work in this area. In *The Nature of Prejudice*, Allport examines the situational threat posed by negative stereotypes. In it, he writes, "One’s reputation, whether false or true, cannot be hammered, hammered, hammered, into one’s head without doing
something to one's character" (p. 142). He suggests that exposure to hammering precipitates internalization of those attitudes, leading to the fulfillment of self-expectancies.

Stereotype threat. Allport's theory has recently been extended to include the effects that stem directly from its posing an acute, and sometimes chronic, situational pressure on a person's life, without any need for internalization to occur (Marx, 1999). C. M. Steele (1997) has coined the term "stereotype threat" to define non-internalized stereotypes as the event of a negative stereotype about a group to which one belongs becoming self-relevant, usually as a plausible interpretation for something one is doing, for an experience one is having, or for a situation one is in, that has relevance to one's self-definition (p. 616). According to Steele, members of a group who fear being reduced to a bad stereotype will experience a process of "disidentification," and will choose to conceive of themselves as separate from a domain that one is in, as a form of self-protection. Distinctly different from internal anxiety, stereotype threat is strictly situational and described by Steele as "a threat in the air." Disidentification precipitated by stereotype threat may account for avoidance, delay, or many other difficulties particularly encountered in the coming-out process in the workplace for those desiring sexual reassignment.

Initial research in stereotype threat has been conducted with several populations revealing that negative stereotypes directly affect performance. Steele and Aronson (1995) found that Black Stanford University students solved fewer
verbal problems correctly than White students when the test was presented as
diagnostic of ability. However, they performed equally as well as Whites when the
test was presented as nondiagnostic. Similarly, Spencer, Steele and Quinn (1999)
examined performance effects of negative stereotypes on women’s math ability.
Results were consistent with expectations. Women under performed compared to
equally qualified men on the math exam, but performed just as well as men on the
literature exam.

The type and degree of stereotype threat appears to vary from group to
group, and for any group across settings. According to theory, one need not believe
the stereotype or even worry that it is true of oneself to experience the threat. For
example, in Steele’s (1997) study, normally high performing African American
students did less well on testing when told that their performance would be
compared with that of students who were White. Finally, researchers consistently
find that attempts to overcome stereotype threat by disproving it, which must be
made repeatedly, are experienced as daunting (Cross, 1995; Steele, 1997; Steele &
Aronson, 1995; Goffman, 1963; Allport, 1954).

It would therefore follow that differently gendered individuals, who identify
with a domain that experiences both internalized anxiety and stereotype threat,
experience situational stressors that will impact on identity development and
present important challenges requiring attention in the realm of supportive
psychotherapy throughout the coming out process.
A Primer of Definitions for the Uninitiated

Before embarking on a review of the literature related to sexual and gender identity development, one must first operationalize several terms whose definitions are often inappropriately interchanged in everyday parlance; specifically, the concepts of sex and gender. An introductory glossary is provided herein, of terms used repeatedly throughout the body of this study. Many are adapted from Shively and DeCecco’s (1993) descriptive model of the components of sexual identity. In it, they distinguish between four fundamental components: natal sex, gender identity, social sex role, and sexual orientation.

Sex, or natal-sex, is a term typically applied at birth, which refers to whether the external genitalia of the newborn visually appear female or male. When genitalia are ambiguous, the child’s sex may be both female and male, or intersexed, historically referred to as “hermaphroditic.” Regardless, both of these terms refer to external appearance (DeCecco, 1993). Conversely, gender, or gender-identity, refers to one’s own internal feeling or sense of being a man, a woman, an intersexed or a transgendered person. The relationship between sex and gender is noncausal. According to Bockting (1999), one’s gender-identification may vary in intensity, in permanence or in completeness of feeling at any given time. One may feel as if one were a man or a woman, or feel both coexisting to varying greater or lesser degrees throughout life, or neither man nor woman. Gender is therefore not the binary schema of male or female, but rather exists along a spectrum or continuum subsuming a myriad of expressions, and may remain fluid over time.
The experience of profound discrepancy between sex and gender identity is what specifically creates the dilemma with which the transgendered individual contends when broaching the notion of transition. *Transgender* is therefore an umbrella term used to encompass many gender identities, expressions and behaviors that are not traditionally associated with one’s natal sex. *Transition* refers to the biopsychosocial and spiritual transit one engages in when moving from one’s natal sex, to one that matches one’s experienced gender identity. For people transitioning, or seeking Sexual Reassignment from female-to-male, medically prescribed administration of testosterone, or Hormonal Sex Reassignment, is the means by which secondary sexual characteristics are developed to reflect the chosen gender, thereby becoming Transsexual. For many, but not all, hormone treatment may be followed by Sex Reassignment Surgery, involving reconstructive surgeries (Shively & DeCecco, 1993).

Shively and DeCecco (1993) make yet a further distinction between one’s gender-role or gender-expression, and one’s social sex role. These terms refer to one’s personal verbal and nonverbal communications to others about their experienced identity, whereas one’s social-sex-role refers only to the cultural stereotypes associated with masculine and feminine characteristics. Hence, transgendered individuals who choose for hormonal and surgical reassignment, after which their sex and gender are congruent, are referred to as Transsexual or transsexed.

Lastly, the terms sexual orientation and sexual preference refer exclusively to one’s preferred object of sexual desire. Succinctly, while sexual and gender
identities refer to who we are as people, orientation and preference refer to how and
to whom we experience erotic attraction. Furthermore, the three components of
sexual orientation, behavior, fantasy and emotional attachment need not be
congruent. One may, for example, be sexual only with women, fantasize about both
men and women, and experience emotional attachment to a transgendered person
(Bockting, 1999).

Research Defining the Construct of Gender

Historically speaking, ‘gender’ is actually an old term that has been
commonly used throughout time to designate whether nouns were masculine,
feminine or neuter in linguistic discourse (Merriam-Webster, 2001). It made its
way into the language of psychology and other social sciences in 1955 when John
Money first used it as an umbrella term to distinguish womanliness and manliness
from biological sex (male or female). He did so in order to simplify discussion in a
case study of an intersexed person (then referred to as a hermaphrodite) in which he
continually needed to qualify that the subject maintained a male sex-role, but that
his sex organs were not male, and that the subject was genetically female (Money,
1955). This first signification that the term “sex” belonged exclusively to genetic,
reproductive biology, whereas “gender” included how one behaviorally and socially
conducted oneself, or how one was regarded legally, has been maintained since
introduced by Money.
More globally, Money noted that the term gender could be used to specify one’s gender identification with masculinity and femininity (gender-identity), but could also be used to make judgments regarding an individual’s level of conformity to social norms (gender-role). Such elements as clothing, body decoration, mannerism, gait, and occupational choice allow others to determine the gender-role of others. When biological sex, gender-identity, gender-role and all of the symbolic representations are manifested in a harmonious way, a person is said to be “gender-congruent” (Denny, 1999). However, depending upon how one defines gender non-conformity, between 10 and 15% of the general population is not gender congruent (Bullough & Bullough, 1993).

Given the impact of social norms in defining gender congruency, the construct of gender is, by nature, bound within a sociocultural context. The term “gender” refers to one’s social status as either a woman (girl) or a man (boy). When the term is conferred by others, as in “it’s a girl,” the cognitive schema attributed is determined and limited to its biological demands. Hence, sex is seen as determining gender. Basic schematic cognitive tools such as these serve to help social beings order, organize and communicate common understanding of shared experience. Thus, children in most societies come to understand the world as inherently bifurcated into male and female schemata, with all experience reinforcing the notion that gender is biologically determined and permanently constrained at birth (Herdt, 1996). While specific male or female attributions may vary widely from culture to culture, the cognitive scaffolding of gender is a universal tool used to understand the world. The cognitive schemata for gender are
established in early childhood and reinforced in both overt and subtle ways throughout life in all societies, functioning as a lens through which all experience is sifted (Deaux & Steward, 2001; Bem, 1993).

Consequently, a plethora of research has attempted to systematically identify, classify, and measure concepts of masculinity and femininity. Early attempts were based on highly unrepresentative samples, including the M-F (male-female) Scale, of the 1940’s Minnesota Multiphasic Personality Inventory (MMPI). Standardized on a sample of 134 people consisting of 54 male soldiers, 67 female airline employees and 13 male homosexuals, the M-F Scale is today believed not to have reflected even the social tenor of its own era (Kesler & McKenna, 1978). Simplistically based on a masculine and feminine continuum, individuals were identified as either male or female, without latitude for any overlapping experience.

Theories then evolved, incorporating the notion that personality was layered, allowing for outward masculinity that might be inwardly feminine (Pleck, 1981). However, The Gough Femininity Scale (Fe), normed in 1952, and upon which much of the research of the time was based, no longer differentiated between male and female U.S. college students by the mid 1960s (Pleck, 1981). It was not until 1974 that Sandra Bem tested the hypothesis posed by Constantinople that masculine traits might exist independent from, rather than in opposition to, feminine traits (Bem, 1974). Bem (1976) introduced the notion that individuals might be both highly masculine and highly feminine, or neither, with the Bem Sex Role Inventory (BSRI). Thus, the concepts of “androgyny” (being equally
masculine and feminine), and “undifferentiated personality” (being neither masculine nor feminine), were introduced into the study of gender. Normed on a sample of 100 college students, half male and half female, the BSRI did not account for variables of class, race, ethnicity, sexual orientation or regionalism. However, it did then, and continues now, to more accurately reflect the zeitgeist than previous attempts at classifying and measuring the phenomena of gender (Devor, 1989).

Concurrent with Bem’s reclassifications for gender roles was research undertaken to determine mental health professionals’ attributions and clinical judgments of sex-role stereotypes (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970). Both Bem (1976) and Broverman’s group discovered that the standards for healthy functioning human beings corresponded highly with the standards of healthy functioning males, whereas the standards for healthy functioning females did not. These differences discovered between the clinical estimations and standards for healthy men and women clearly revealed a more positive value placed on masculinity than on femininity. Masculine men were rated as having the greatest self-esteem, self-confidence, and flexibility, while feminine females exhibited the least of these qualities (Bem, 1976). Benjamin (1966) conducted a survey in which women were found to be 12 times more likely than men to have preferred to be born male. Similarly, Jones, Chernovetz and Hanson (1978) found that both feminine males and feminine females wished to become more masculine. Thus, by the 1980s, the scientific literature clearly acknowledged the impact and power of gender as a set of ubiquitous cognitive, ideological and sociological constructs that significantly color all of human experience.
Moreover, the advent of feminist studies in the psychology of women introduced a sociopolitical understanding of patriarchal influences upon identity development (Unger, 2002). It is possible that the women’s movement is in part responsible for both the normalization of women emulating male gender-roles, and also responsible for the minimization of the phenomenon of female-to-male transgender as an exclusive result of socialization, thus discounting significant differences between women who are male identified from those who feel as if they were men born into a woman’s body.

_Acquisition of Gender_

The question of how gender identity is acquired is the core dilemma of transgenderism. There are four prominent theoretical models of gender acquisition: (1) the psychoanalytic identification theories originated by Freud, (2) Bandura’s (1977) social learning theory, (3) cognitive developmental models of Kohlberg (1966) and Gilligan (1982), and (4) Cass’s (1979) gender-schema theory as applied to sexual minorities.

_Psychoanalytic theory_. Psychoanalytic theory posits that gender evolves as a result of a universal innate intrapsychic predisposition for children to identify with their same-sex parent within the first year of life (Freud, 1962). Boys are believed to imitate their fathers’ dominance as experienced within the family system, and girls are believed to imitate and identify with their mothers’ nurturance and
feminine attractiveness to men. The theory posits that children pass through stages of imitation and identification independent of social systems or customs (Stoller, 1968). According to analytic theory, gender incongruency might therefore develop intergenerationally, as a consequence of the parent's own intrapsychic gender conflicts, and resulting unconscious gender-incongruent behaviors with which the child identifies. This has, in fact been theorized by many (Bradley & Zucker, 1995; Lothstein, 1983; Bradley, 1998; Green, 1974).

Adlerian theory, which does not speak directly to the acquisition of gender, does however alludes to the power of its role in personality development, and provides a precursory bridge between psychoanalytic, social learning, cognitive and gender schema and existential theories. Adler (1917) was among the first to posit that culture devalued women as compared to men. He theorized that regardless of the strength of the bond and identification with the same-sexed parent in early childhood, cultural devaluation was intergenerationally transmitted and introjected by the female child as psychological inferiority. Moreover, according to Adler, any differences, abnormalities or weaknesses, such as the feeling of gender-dysphoria, would result in a feeling of psychological inferiority. However, he posited that these inferiorities had the innate power to propel individuals to strive toward creative, choices, allowing the adult to convert psychological loss into gain (Adler, 1917; Ansbacher and Ansbacher, 1956).

Social learning theory. Conversely, Bandura (1977) directly disputed the notion of innate predispositions to behave in gendered ways. The school of social
learning posits that gender is a cultural artifact. Neonates are believed to be blank slates, and malleable to the demands and expectations of the societies into which they are born. Hence, given the opportunity, individuals are not limited to same-sex identification, but rather, are capable of learning a multitude of cultural meanings for gender (Bandura, 1977). By this definition, one might theorize that whatever adult influences culturally predominate throughout early childhood, are those that determine the gender status of the child.

*Cognitive theory.* The cognitive developmental school of gender acquisition (Kohlberg, 1981; Gilligan, 1982) is similar to social learning theory in its agreement that gender is learned through experience. However, it sees the child as having an inherent need to make sense of the world, and as one who actively initiates and compels the learning process. Cognitivists also see the very young as having an innate disposition: one of active participation in organizing the world and classifying behaviors. Ultimately, the use of male and female as categories become an increasingly more sophisticated and nuanced filtering device. Kohlberg (1966) theorized that a child’s ability to identify his or her own gender status correctly was a first stage task in “gender consistency” development, the end state of which he identified as gender invariance. Thus, according to the Cognitivists, the combined results of the early-childhood cognitive developmental process of classification and social shaping account for the natural bifurcation of male and female gender in society.
Gender schema theory. Both social interaction and the cognitive search for meaning are integral to gender schema theory, which posits that while the need for schematic information is innate, gender schemata are socially imposed preferences (Bem, 1993). Thus, once learned, gender becomes a rationale for one's own and others' behavioral expectations. Consequently, the better one learns to conform to gender-linked social expectations, the better one fares in society.

Biological Contributions to the Dilemma of Gender Congruence

A glaring omission in each of the aforementioned theories is the absence of any discussion of possible biological contributions to the acquisition of gender. In fact, one's gender identity is now believed to result from a dynamic relationship between nature and nurture. Panskepp (1981) posits a feedback loop between hormonal systems, prenatal dispositions and social environment. If positive, hormones and the social environment reinforce one another, enhancing the prenatal disposition. However, she suggests that the effects of environment can also override the prenatal influence so much that it becomes overshadowed by the demands of the social environment.

In particular, the hypothalamus, which controls the endocrine system and sex hormones, differs in males and females (Arnold & Breedlove, 1995; Hoenig, 1985). Several studies (Devor, 1989; Panskepp, 1981; Siegel & Edinger, 1981) now indicate that prenatal hormonal baths occurring throughout gestation create a cyclical release of sex hormones in females, but an acyclical release in males, thus
determining secondary sexual characteristics and reproductive behaviors. The secretions and sensitivity of the hypothalamus determine individual regulation of hormone levels. Hence, many argue that “maleness” or “femaleness” is set by the hypothalamus in fetal life, and that the frame for learning of certain behaviors is determined before birth and reinforced or overshadowed by the social environment in the first years of life.

Specific empirical studies comparing androgen levels in adult men and women have been conducted in attempts to understand differences between gender congruent females and female-to-male reassignment candidates. Bosinski, Schroder, Peter and Reinhard (1997) compared androgen levels and anthropomorphic measures in males, females and hormonally untreated female-to-male groups. Female-to-male were, in fact, found to have significantly higher testosterone and SHBG (sex hormone binding globulin) than the female group. Additionally, fat distribution and bone proportion in the hormonally untreated female-to-male group was similar to those for the male group, further supporting a biological etiology of transgenderism.

Regardless of etiology or theoretical approaches to gender identity formation, there is general agreement that gender identity, or one’s sense of being male or female, is consolidated by age 3 or 4 (Bradley & Zucker, 1997). By age 4 or 5, the emergence of sex-stereotypic gender role behaviors becomes apparent. Finally, latency typically brings a gradual shift toward a more flexible understanding of gender. However, most children continue to display a preference
for gender-typical activities, and to exclude or reject children who appear to
significantly deviate from the norm (Bradley & Zucker, 1997).

Definitions: Transgendered vs. Transsexual

The term “Transgendered” covers a wide spectrum of beliefs, attributions
and behaviors that fall along a continuum. Kessler (1997) provides a deconstruction
as follows. The prefix “trans” may mean change, as in changing one’s physical
anatomy to match a gender they feel they always were, and becoming transsexual;
or it can mean across, as in one who moves across gender or some aspect of it,
without any hormonal or surgical intervention. These individuals emphasize
crossing genders. In either case there remain two genders. However, “trans” may
also mean beyond or through, as in the word “transcutaneous,” a more radical
definition in which no clear gender is attributed to oneself, maintaining the belief
that one has gone beyond the confines of gender. Great debate exists in the
literature of the transcultured community regarding whether or not transgendered
persons who do not opt for medical intervention may also be considered
transsexual, and whether those who use medical intervention should use the term
transsexual at all (Devor, 1999; Cromwell, 1999; Bullough & Bullough, 1993).

Whether one self-identifies as transgendered or transsexual, the feeling of
incongruity between one’s sex and gender generates what mental health
professionals commonly refer to as dysphoria. The word “dysphoria” comes from
the Greek word meaning “hard to bear” and is defined by most dictionaries as a
feeling of unease or mental discomfort (Merriam-Webster, 2001). For most, this feeling of being born to the wrong sex, or in the wrong body, is known in the medical literature as gender dysphoria or Gender Identity Disorder (GID) (DSM-IV, 1994).

*The Diagnostic and Statistical Manual-IV* (1994) describes GID as coming and going throughout life, but pervading all aspects. It may be gone for a few hours, days or as long as a few months, but significantly, it always returns. Criteria for the diagnosis of GID include two major components, both of which must be present for the diagnosis to be made:

There must be evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex (Criterion A). This cross gender identification must not merely be a desire for any perceived cultural advantages of being the other sex. There must also be evidence of persistent discomfort about one’s assigned sex or a sense of inappropriateness in the gender role of that sex (Criterion B). The diagnosis is not made if the individual has a concurrent physical intersex condition (e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia) (Criterion C). To make the diagnosis, there must be evidence of clinically significant distress or impairment in social, occupational or other important areas of functioning. (DSM-IV, 1994, pp 522-523).

In Vitale’s (1996) 18-year longitudinal review of 200 adults presenting with GID, five distinct anxiety stages were revealed, paralleling standard periods of developmental anxiety. She found that childhood anxiety began as early
as 4, with adults reporting that they hoped and prayed during childhood that the dysphoria would disappear or be taken away by God. Virtually every respondent indicated desperately wanting to discover hidden sex organs of the desired gender in later childhood. Increased freedom allowed by the stage of adolescence provided some reduction in anxiety through the ability to cross-dress in varying degrees. Early adulthood was found to fundamentally amplify the intensity of attempts to rid oneself of anxiety, and was therefore the stage when professional help was most frequently sought. Female-to-male effecting androgynous appearance and embracing the lesbian community registered reduced anxiety as compared to male-to-female respondents who did not have a community within which to blend. Anxiety was found to be magnified between ages 28 and 33, when one assesses one’s aspirations, often dictating whether an appeal for surgical reassignment was made, or conversely, heightened anxiety, depression and suicidal ideation ensued in midlife (Vitale, 1996).

_A Brief History of Sex Reassignment Surgery_

Very few surgeons were willing to fulfill the wishes of those patients requesting sex reassignment surgery in the early 20th century, as the prevailing belief was that the wish to reassign one’s sex was a pathological urge (Lothstein, 1980a). The first known sex reassignment surgery (SRS) is believed to have been performed in 1912 by Hirshfeld, and only a handful of single case studies were
reported in the 1920s (Pfaffin & Junge, 1998). In Nazi Germany, where sexual minorities were viewed as a threat to the purity of the Aryan race, hormonal and surgical sex reassignment procedures were conducted on homosexual internees as a means of experimental torture (Herdt, 1996).

However, by the 1950s, following the international media exposure of Christine Jorgansen, who underwent SRS in Denmark, controversial dialogue began among American psychoanalysts who were meeting with minimal success in their attempts to cure the symptoms of transsexualism (Lothstein, 1980). Simultaneously, Jorganson sought out Dr. Harry Benjamin, an endocrinologist, to field the overwhelming number of patient requests for information regarding the procedure. The result of this deluge of inquiry was the establishment of the Harry Benjamin Gender Identity Dysphoria Association (HBIGIDA) in 1964. It appears that what unified endocrinologists, psychologists, psychiatrists and surgical specialists was the adoption of a body-centered treatment and antipsychodynamic stance (Pfafflin & Junge, 1998). Stoller, (1985) one of the few early psychoanalysts to support sex reassignment surgery, began to highlight Money's original efforts to distinguish between sex and gender, ultimately contributing greatly to the establishment of hospital gender committees and gender identity clinics (Raymond, 1979).

Review of the Empirical Studies of Sex Reassignment Surgery (SRS)

One of the few consistent findings is that occurrence of male-to-female SRS is far more frequently reported than female-to-male reassignment, (Laub & Fisk,
1974; Eicher, 1984; Cohen-Ketteris & van Goozen, 1995, 1988), Pfaefllin & Junge, 1998). However, multiple problems are evident when reviewing published systematic compilations of SRS outcome studies before the 1980s. There is little consistency among samples with regard to size or representativeness. The spectrum of protocols and procedures varies greatly between studies, depending on whether they were conducted in the United States, Europe or Scandinavian countries. Follow-up study periods also vary significantly. While all studies appear to examine for patient adjustment and satisfaction, neither construct seems to be uniformly operationalized, nor is there any consistent use of measures. Most studies were limited to interview and nonstandardized self-report inventories. Only Hunt and Hampson (1980) included the Minnesota Multiphasic Personality Inventory, a statistically valid and reliable measure.

Moreover, the prevailing belief held before 1980 was that psychological intervention failed to reconcile transgendered patients with their inborn physicality, and therefore could not influence outcome of SRS. Consequently, few if any studies accounted for the function of pre- and post-surgical psychological treatment as variables contributing to adjustment and satisfaction (Pfaefllin & Junge, 1998). In fact, there appears to be no references made to length, frequency, content or methods of psychological intervention despite indications that it was mandated or occurred. Only psychopathological portraits appear to be offered in the literature for the distinct purpose of justifying surgical procedures.

Effectiveness of single pre- and post surgical psychological treatment components were, however, examined in a handful of studies in the 1980s
(Blanchard, 1989; Kuiper, 1985; Fahrner, Kockett, & Duhan, 1987; Kuiper & Cohen-Ketteris, 1995). These studies posed Eysenck’s (1952) question, “If treatment is useful, which treatments, under what sets of circumstances is useful to whom.” As a result, four areas of study emerged: (a) prognostic typology; (b) comparative results for male-to-female and female-to-male samples; (c) comparative results for treatment facets; and (d) examination of long-term effects of programs’ nonadmittance of candidates for surgery. Extensive agreement can be found among studies indicating that the presence of psychosis and remittent psychosis are contraindications for sex-reassignment treatments (Mate-Kole, et al., 1990; Blanchard, Steiner & Clemmenson, 1985).

Other precipitants of poor outcomes, which have ultimately become treatment exclusion criteria, are epilepsy, personality disorders, sociopathy, and substance abuse. Suicidality, also a criterion for exclusion, was found to be very rare following SRS treatment. Outcomes were proportionately better the fewer psychopathological traits were noted at time of intake, with mental stability and high ego-strength being the best indicators for successful outcome (Mate-Kole et al., 1990; Blanchard, 1985; McCauly & Ehrhardt, 1978; Wallinder, 1997; Lothstein, 1980b; Kando, 1973).

Pfaefflin and Junge (1998) estimated that the global percentage range for satisfactory or ‘positive’ SRS outcome results for females varied from between 68% (Lothstein, 1983) and 87% (Green, 1989). The global range of satisfaction for males ranged from 86% (Lothstein, 1983), to 97% (Green, 1989). Unsatisfactory or
‘negative’ results ranged from 8% (Pauly, 1981) to 13% (Green, 1989) for females, and from 6% (Pauly, 1981) to 3% (Green, 1989).

With specific regard to female-to-male samples, most studies determined that if the subject were able to pass more or less unnoticed as a man, and was over the age of 21, treatment outcome could be projected to be positive. It was also found that “if the patient can establish his or her claim to be a member of the other gender in a way allowing him or her to get along well socially and earn a living, this requires a not inconsiderable amount of ego strength” (Pfaflin & Junge, 1998, p. 92). Thus, successful passing and financial self-sufficiency were found to be presurgical social factors predictive of successful transition over time.

Pfaflin and Junge (1998) identified six specific factors in the literature that best predicted effective treatment results for the transgendered individual seeking to become transsexual: (1) On-going contact with the treatment team; (2) consistently living within the other gender role; (3) hormone therapy; (4) psychological intervention; (5) high-quality sex-reassignment surgery; and, (6) legal recognition of gender change by name, and legal recognition of sex change. There is great agreement among researchers that, given the inclusion of these factors, gender reassignment treatment is effective in lessening suffering and increasing subjective satisfaction for those individuals whose gender and sex are incongruent (Benjamin, 1966; Cohen-Ketteris & van Goozen; Diamond, 1966; Etter, 1999; Haraldson, 2000; Hoenig, 1995; Lothstein, 1982; Mason-Shrock, 1996; Mate-Cole, Freschi & Robin, 1990; Pfaefflin & Junge, 1998; Rachlin, 2001).
Models of Sexual Minority Identity Development

The process of coming out to self and others as gay or lesbian may be defined as a series of struggles with identity, awareness, acceptance and affirmation, precipitated by the social expectations of heterosexuality placed upon sexual minorities (Fassinger, 1991). It is a difficult developmental process that may not be completed until well into an individual’s adult years. For the transgendered and transsexual, who may or may not undergo a coming out process regarding sexual preference, the process of coming out as “differently-gendered” constitutes similar significant challenges. A review of the extant research on developmental models of minority sexual identity formation is therefore offered as a potential parallel template for the coming-out process for transgendered individuals.

Two theoretical schools dominate the literature on sexual identity formation: The schools of Essentialism and Social Constructionism. Essentialism has its origin in the biological model, which argues that one’s fundamental way of being is determined prenatally or by early childhood. One is believed to be either innately heterosexual or homosexual (Mosher, 2001). Essentialists define coming-out as “merely a process of learning to recognize and accept what one was all along” (Kitzinger & Wilkinson, 1995, p. 95). Thus, biology underlies identity formation, a process of recognition, acceptance, restructuring of identity and, ultimately, disclosure.

Several essentialist stage models of identity development specific to sexual minorities have evolved for the purpose of helping psychologists to properly
recognize, predict, articulate and normalize common life experiences, and treat them as normative developmental issues, rather than indications of pathology. Each model describes the development and management of a stigmatized identity as a progressive movement through several stages toward self-affirmation and disclosure. One’s identity as gay or lesbian is believed to move from the outer recesses of self-concept to an acknowledged core part of the self. Some models have focused exclusively on lesbian identity formation (Chapman & Branhock, 1987; McCarn & Fassinger, 1996; Sophie, 1987); others describe gay development (Minton & McDonald, 1984), and several are inclusive of both lesbian and gay identity formation (Cass, 1979; Coleman, 1982; Troiden, 1989).

Only Cass’s (1979) classic six-stage theory of gay identity formation, which was the first published model, has been empirically validated by at least a limited number of studies (Cass, 1984; Kahn, 1991; Levine, 1997; Lark & Croteau, 1998). Cass designed questionnaires and the Stage Allocation Measure (SAM), administering the study in Australia and again in the United States. Her model has been criticized for having been developed exclusively on the experience of gay males and therefore not applicable to lesbians (Hequembourg & Farrell, 1999), and most recently for suggesting, contrary to current evidence, that lesbian sexual identity only begins at puberty (Whitam, Daskalos, Sobolewski, & Padilla, 1998).

According to Cass (1979), the motivation for development is based on interpersonal congruence theory, which posits a need to ameliorate interpersonal and socially referent incongruencies presented at each stage. Individuals may work through a stage or terminate forward movement by undergoing “identity
foreclosure.” A summary of the stages is as follows. In Stage 1, “Identity Confusion,” one questions the assumption about one’s sexual orientation. Stage 2, “Identity Comparison,” involves feelings of isolation and alienation from both prior assumptions and heterosexuals. Stage 3, “Identity Tolerance,” involves seeking out others of the same persuasion and tolerating a lesbian/gay identity. Stage 4, “Identity Acceptance,” involves selective identity disclosure to others. Stage 5, “Identity Pride,” involves immersion in lesbian/gay culture and a rejection of heterosexual values. In Stage 6, final stage, “Identity Synthesis,” lesbian/gay identity becomes one aspect of the self instead of an overriding independent personality (McCarn & Fassinger, 1996). A similar cognitive, affective and behavioral approach is taken by most of the models, revealing significant importance placed on a stage similar to Cass’s Identity Acceptance, during which disclosure is identified as a necessary element precluding identity foreclosure.

However, significant exceptions to this model have been made in the past 5 years by Social Constructionists. Largely influenced by racial and ethnic identity research and postmodernism, these theorists have challenged stage models for ignoring the social context and contingencies bearing upon the process of coming out to oneself and society. Focusing less on etiology, treatment and adjustment to the majority culture, and more on the understanding of individual experiences and situations in the lives of nonheterosexuals, they argue that the majority culture and language create an inability to define one’s sexual feelings. Therefore, Social Constructionists incorporate a study of the creation of common defenses used to deny, negate, minimize or ignore nonheterosexual feelings (Mosher, 2001).
Among this second group of theorists are Carrion and Lock (1997), who criticize essentialists, such as Cass, for attributing passing behaviors, (or behaving as if one were a heterosexual), as being a developmental foreclosure, or untrue to one's essential being. Rather, they see passing as a self-preservation technique in a society that is often violent and homophobic. Similarly, the stage of identity confusion seen in essentialist models of identity formation is described by Social Constructionists as less of an intrapsychic process, and more as an interpersonal reaction to ambiguous experiences of rejection during social contact. Thus, theorists in this school attend to intrapsychic and interpersonal aspects separately in defining the process of coming out (Carrion & Lock, 1997; McCarn & Fassinger, 1996; Ossana, Helms, & Leonard, (1992). They posit that Cass and others conflate personal identity formation with reference group components of identity, and minimize the impact of social prejudice and oppression upon coming-out disclosure processes.

Social Constructionist theory and research into sexual minority identity formation is largely predicated on Cross's (1971, 1987) early study of racial and ethnic identity formation research. He distinguished between two sectors, representing differing branches of simultaneous development: the sector of personal identity, and the sector of "reference-group identity." In this model, personal identity is comprised of one's self-evaluation and self-esteem. However, reference group orientation is also developmentally tracked, as seen through race or group awareness, orientation and identity.
In the original research developed during the civil rights movement, Cross, (1971, 1987) specifically validated the stages of liberation crossed by Black activists as “The Negro-to-Black Conversion” using a Q-sort methodology to articulate five stages: (1) Pre-encounter, involving naiveté and dependence of White dominance; (2) Encounter, in which the individual’s view of self and other Blacks is challenged; (3) Immersion and Emersion, involving immersion in the Black world and hostility toward Whites; (4) Internalization, or the incorporation of new learnings within self-concept; and (5) Internalization and Commitment, representing a transformation to conscious anger, self-love and Black communalism.

Three models attempting to generalize Cross’s model to identity development of any cultural minority were found in the literature. Atkinson, Morton and Sue (1989) provided a similar five-stage model addressing four attitude areas: (a) view of self; (b) view of others of same minority; (c) views of those of another minority; and (d) views of majority group individuals. Similarly, Myers and colleagues’ (1991) model for self-identification in oppressed people involves a fluid spiral of six phases, in an attempt to attack the oversimplification of linear models. Reynolds and Pope (1991) offer a multidimensional model with four possible options for identity resolution in those who are members of multiple oppressed groups, incorporating personal needs, reference groups and environmental demands.

Finally, Devor (2002) recently presented a yet unpublished stage model of transsexual identity development (Personal communication, 2002; Appendix D),
which is similarly adapted from Cass’s original model. Devor’s model includes 7 additional stages, representing periods of delay and retraction. This expansion of the model is possibly due to the visibility and permanence that the goal of sex reassignment contributes to the coming out process for transsexuals, and is discussed at greater length in the theoretical analysis of the findings of this study.

**Disclosing Gender-Variance: Coming Out to Others**

An underlying premise of this study is Pafflin and Junge’s (1998) findings that two of the most critical venues for negotiating the coming out process are that of family-of-origin and the workplace. Unlike the gay, lesbian or bisexual individual, the transgendered person will be unable to pass or conceal his or her gender identity once hormonal treatment is begun. In order to fulfill pretreatment candidacy requirements, one must first pass the “Real-Life-Test/Experience” mentioned earlier, and function on a 24-hour basis in the role of the desired gender for at least 3 months prior to approval. Approval for and initiation of hormone treatment thus make nondisclosure a moot point. For the female-to-male candidate, secondary sexual characteristics gradually evolve over the course of the first year, often including some or all of the following changes: a broadening of facial structure, growth and thickening of body and facial hair patterns, sometimes including male-patterned baldness; thickening of vocal cords with deepening of the voice; distinct morphological changes consistent with the male physique, due to the redistribution of body fat; cessation of menstruation and reproductive functioning;
increased libido; and enlargement of the clitoris (Brown & Rounsley, 1996). The pretreatment approved candidate must consequently prepare significant others in his or her world for this visible and dramatic transition. Concomitantly, the majority of sex reassignment outcome studies conclude that the long-term degree of satisfaction with transsexuality is largely dependent upon two eventual factors: (a) acceptance and support of immediate family, and (b) on one’s ability to be financially independent as a result of sustaining meaningful employment (Pfaefflin & Jungee, 1998). The ability to sustain meaningful employment and be self-supporting may be understood as a measure of ego strength necessary to enduring the stress of real life consequences that are inherent in undergoing transition.

Coming Out to Family: Parental Reactions

Although many autobiographical coming out accounts written by transsexuals reflect a fear of loss of parental love, there exist no formal studies in family reaction and adjustment to disclosure of intent to transition to another gender. A handful of gender-specialist psychologists have published guides to clients and clinicians, based on their clinical practice, observations and experience (Brown & Rounsley, 1996; Ettner, 1999; Israel & Tarver, 1977; Ramsey, 1996). Their patients’ experiences appear to universally indicate that regardless of one’s gender, mothers seem generally better at adapting to disclosure and transition. These authors counsel clients to carefully assess the consequences of disclosure both with family and in the workplace, to determine whether coming out will
improve the relationship. Also commonly suggested are “disclosure letters” explaining one’s intentions within the contexts of life, family and work. In her sociological study of 27 female-to-male subjects, Devor (1997) found that 67% of the 42 mothers in her sample responded positively, believing their children’s “bodies wrong, and minds right” when the subjects “authoritatively told family that transsexuality is caused by unobservable, biological mechanisms impervious to family dynamics” (p. 434).

Consistent with this manuscript’s assumed paradigm, the transgendered coming-out process is theorized to partially parallel those of other sexual minority groups. A review of the literature relevant to disclosure and family reaction is provided from formal studies of gay, lesbian and bisexual families.

There is a sizable literature base exploring the process by which parents evolve from a state of shock to one of acceptance of their gay, lesbian or bisexual child (Bozett & Sussman, 1989; Mahoney, 1994; Meyers, 1982; Robinson, Walters & Skeen, 1989; Strommen, 1990; Wirth, 1978). All of these studies have been predicated on Kubler-Ross’s (1969) model for grief and mourning, which articulated five linear stages: denial and isolation, anger, bargaining, depression, and acceptance. According to Mahoney (1994), parents mourn:

... the loss of the heterosexual identity of their child and their hopes and dreams and expectations for a traditional life for their lesbian or gay child; the lack of grandchildren and the special relationship of being in a grandparent role; ... their perceived lack of success as parents and as
individuals; ... and the improbability of changing their child's orientation (pp. 24-25).

Thus, Mahoney suggests that parents initially experience shock and denial upon disclosure of sexual orientation. If the relationship between parent and child has been ambivalent, conflictual, or distant prior to disclosure, this first stage may be prolonged. During this period, family relationships tend to be tense in the presence of the gay child, and relaxed in their absence, due to the ability to temporarily deny the issue.

The second stage of anger and frustration is one in which the child and his or her peers are blamed or scapegoated. Bargaining follows, with threats to disown or disinherit the child, or promises of financial support if he or she will change or conceal orientation.

The fourth stage of depression evidences more typical forms of grief, including sadness and weeping, isolation and withdrawal from relationships, or somatic complaints on the part of parents or children. Finally, upon the realization of the loss, parents were found to accept their child and to begin to express concerns for him or her.

By contrast, other researchers examining family reaction and adjustment to disclosure of a child's sexual orientation disavow the grief model, finding families to have individualized and diverse reactions (Mahoney, 1994; Savin-Williams, 1998). Patterns revealed that mothers initially tended to report guilt and shame, while fathers' initial instincts were to deny and reject. However, studies such as D’Augelli and Hershberger's (1993) examination of parental reactions 9 months
post disclosure found that between half of the mothers and 37% of the fathers accepted their child within a year of disclosure, about one fourth of the mothers and 36% of the fathers were tolerant, and only one quarter of the mothers and 28% of the fathers were rejecting or intolerant of their child’s orientation. Negative reactions to disclosure appeared to be related to lack of exposure to sexual minorities and lack of frank information, which was rarely found in the literature of the past decade (Ben-Ari, 1995; Savin-Williams, 1995).

Self-reflection appears to be the major dilemma faced by parents whose children disclose their sexual identity as gay male, lesbian or bisexual. Williamson (1998) sees disclosure as a particularly complex event because it elicits parents’ conscious and unconscious anxiety regarding their own sexual identity, sexual history and impulses, and calls into question their own morals, values and role modeling. He counsels that this profoundly unsettling event can be less traumatizing for parents if the child prepares by rehearsing well-chosen words for the disclosure in therapy, prior to pronouncing his or her orientation.

It is a generally accepted psychological principle that the level of intimacy between all human beings is a function of openness and self-revelation, and that secrets have a destructive effect on family life and relationships. Consequently, literature in the field of family therapy provides models by which families may be helped to accept a child’s sexual orientation (Crosbie-Burnett, Foster, Murray & Bowen, 1996, 1993; Strommen, 1990). These authors have adapted Bandura’s (1977) social-cognitive-behavioral model of reciprocal determinism to family systems of gay children. Beliefs, attitudes, meanings, values, attributions, fears and
behaviors of family members can affect family boundaries, hierarchy, communication patterns and subsystem structures.

The therapist’s chief task is therefore to assist family members in creating shifts in their schemata of self and family, to enable enhanced problem-solving, conflict resolution, and managing disclosure of this information as appropriate to extended family and friends.

*Coming Out in the Workplace*

One’s livelihood is the next most likely arena to be threatened in the female-to-male’s coming out process. The workplace is therefore the second venue under examination in this study. Outcome studies cited earlier clearly identify employment as a predictor of overall satisfaction following sex reassignment (Hunt and Hampson, 1988; Pfaefflin & Junge, 1998). However, for the transgendered, the ability to earn a living is not solely dependent upon skill, education, motivation or work attitudes. The ability to negotiate and cope with the varying degrees of stigma-threat and outright discrimination bear heavily on the transsexual in the workplace.

Although federal anti discrimination laws have codified the impermissibility of discriminating against lesbians and gay men in the workplace, the transgendered continue to remain largely unprotected by the legal system. The United States 9th Circuit Court of Appeals found that the Employment Non-Discrimination Act does not protect anyone displaying nontraditional gender expression. As of May 2001,
only two states explicitly forbid discrimination against the transgendered: Minnesota and Rhode Island. Rhode Island’s law defines “gender identity or expression” as:

including a person’s actual or perceived gender, as well as a person’s gender identity, self image, appearance, expression or behavior, whether or not that gender identity, self image, appearance, expression or behavior is different than that traditionally associated with the person’s sex at birth (Rhode Island House of Representatives Bill H5920: May 2001).

The cities of Santa Cruz and Berkeley, CA; San Francisco, Seattle, Boulder, Cedar Rapids, IA; Minneapolis-St. Paul, MN; and Philadelphia have passed ordinances explicitly including prohibition of discrimination against their transgendered citizens. And, in the face of great on-going controversy, San Francisco recently included coverage of pre- through post-sex-reassignment treatment as among the health benefits offered municipal employees.

There also exist a very small number of “transgender-friendly” private corporations, such as Apple, Inc. and Lucent Technologies, which maintain published policies and procedures for the transitioning person who is coming out at work. The guidelines are so sensitively inclusive that they explicitly discuss who to tell and how, and how to address issues of name and clothing change, as well as suggestions for addressing restroom issues for both the individual transitioning and both supportive and non supportive co-workers (Horton & Asche, 1999).

Transgendered workers living outside the aforementioned areas of the country, or who are not employed by a corporate business with such a unique
human relations policy, are without legal protection. It therefore stands to reason that gaining and sustaining employment looms large for the transgendered in all phases of contemplating disclosure. The findings of multiple studies exploring the relationships between communication about sexual orientation and work attitudes, performance and satisfaction for gay men and lesbians reveal that open communication is, indeed, a positive predictor of job success and satisfaction (Adams & Brown, 1989; Day & Schoerade, 1997; Levine & Leonard, 1984; Mathieu & Zajac, 1990). While gays and lesbians may opt to remain closeted and not communicate their sexual orientation at the expense of job satisfaction or performance, the transgendered individual embarking on transition cannot. Disclosure is therefore an undeniable and unavoidable task inherent in coming out in the workplace.

Research Questions

This study seeks to articulate the challenges faced by female-to-male transsexuals as they negotiate the impression management and risk-taking processes of explicitly revealing their gender identity to significant people in their daily lives. Consequently, a qualitative approach is adopted, posing research questions rather than specific hypotheses typical of quantitative research. The objective of eliciting richly detailed narrative data by means of semi structured interviews necessitates the use of broad and open-ended questions.
Question domains are based on Pfaefflin and Junge’s (1998) research citing interpersonal stability and the ability to financially sustain oneself in the workplace as the chief predictors of successful transition. Domains therefore include exploration of one’s own and others’ experiences during coming out to one’s family, and in one’s place of employment. Social disclosure precipitants, decision-making processes and strategies for disclosure are explored for both domains. Overall quality of life issues are also explored.

Specific examples included: (a) Tell me your story of coming out as a female-to-male to your family; (b) Tell me your story of coming out as a transsexual at work; (c) Did the real experience of coming out match your fears, anxieties, hopes and expectations?; (e) In what ways, if any, did disclosure change your pre-existing relationship with your parents or employer and coworkers?; (f) How are you and your life different today as compared to prior to coming out to significant others?

The following chapter on qualitative methodology will elucidate how analysis of responses to these questions was able to reveal global themes and patterns in the female to male coming out process of disclosure to self and others.
Participants

Eleven female-to-male transsexual volunteer participants formed the convenience sample. Recruitment of respondents was accomplished through the use of two venues: (a) formal announcement made at local support groups, and (b) advertisements placed on internet list servers developed exclusively for and by female-to-male transsexual individuals. Subjects were limited to English-speaking respondents older than 21 who (a) were currently engaged in the real-life test, and who were in the process of coming out to family and co-workers, (b) who were in any stage of hormonal or surgical reassignment, or (c) had completed their reassignment treatment. All participants were required to provide a letter from a professional indicating that they were in the process of reassignment, as dictated by The Harry Benjamin International Gender Identity Dysphoria Association Standards of Care (HBIGIDA) (2001). Categories B and C were the primary selection source.

Of the respondents, 13 fit the inclusion criteria and agreed to participate in the study. One of the original 13 participants was excluded from the sample due to difficulties in scheduling the interview. Another of the original 13 completed a lengthy interview. However, the audiotape was of poor quality, precluding the
possibility for verbatim transcription. Data was therefore gleaned from the taped
interviews of the remaining 11 participants.

Each respondent consented in writing to all conditions of the research, as
dictated by the Institutional Review Board of the Philadelphia College of
Osteopathic Medicine, and were provided a summary of the results of the study
upon written request. An ongoing methodological qualitative process discussed in
the Data Analysis and Interpretation section of this study was used to determine the
actual number of subjects ultimately included in the study.

Research Design Overview

Rationale for a qualitative model. Qualitative research methods have been
consistently applied to sexuality studies since the 1970s. Predicated on the work of
phenomenologists and symbolic interactionists from the fields of anthropology and
sociology, the qualitative approach to studying sex and gender has allowed the
researcher to identify the social and interactional processes by which meaning
transforms experience into social categories. This constructivist approach to the
study of sexual and gender identity allows for making sense of, and interpreting,
phenomena in terms of the meanings people bring to them.

According to Gagnon and Simon (1973), “Sexuality is not a stable
phenomenon of nature to be studied like plants and cells, but as a set of meanings
attached to bodies and desires by individuals, groups and societies” (p. 352).
Additionally, the meanings can never be divorced from social and political relations (Foucault, 1978).

There is also a long tradition of using the qualitative method for the purposes of depathologizing minority populations who were long perceived by the psychiatric community as deviants needing cures (Gamson, 2000). It therefore seems well suited to the transgendered who, perhaps more than any other group of individuals, confound the categories of sex and gender, and who continue to be pathologized.

The nature of this study is exploratory, and therefore not designed to test a hypothesis. Rather, this investigation examines a complex social phenomenon: that of the coming out process of female-to-male transsexuals. In order to do so, a qualitative research design is adopted, which allowed for data gleaned from subjects' narratives to generate theory. Specifically, formal analysis was conducted of the entirety of verbatim transcripts derived from semistructured, indepth interviews. This qualitative design is adopted over the more traditional statistically derived quantitative analysis to eliminate the potential of threatening or diluting the integrity of the depth and complexity of the data. Strauss (1996) distinguishes between the varied usefulness of these methods as follows:

If someone wanted to know whether one drug is more effective than another, then a double blind clinical trial would be more appropriate than grounded theory study. However, if someone wanted to know what it was like to be a participant in a drug study, then he or she might sensibly engage in a grounded theory qualitative study (p.37).
Grounded theory methodology and its history. The aforementioned method of qualitative inquiry was developed and coined "Grounded Theory" by Glazer and Strauss (1965, 1968) in the early 1960's while engaged in a field study of hospital staffs' handling of dying patients. Using a method of comparative analysis of transcripts, they inductively uncovered "core categories" of dying awareness, as well as a dying "trajectory." Their method involved the absence of manipulation of events and content so that the reality and perspective remained that of the subject. Glazer and Strauss did not embark on their study with a hypothesis or theory. Rather, it emerged from a funneling down process that ultimately generated the core categories and trajectory theory. They coded their transcripts on a line-by-line basis. The theory emerged from this coding of data. Thus, the theory was grounded in the data (transcripts).

Glazer and Strauss parted ways since their original research, each developing differing approaches to the coding process of grounded theory. While they both agree that coding is an essential part of transforming raw data into theoretical constructions of social processes, a great debate has emerged regarding how it should be done. Glazer (1976) remains a purist, insisting that categories not be selected prior to their emergence from the data. He insists against forcing data into any particular scheme, so as not to lose grounding.

Strauss teamed up with Corbin (1990) to produce a coding system that they present as "paradigm model" (p. 96). Six predetermined axial coding categories are presented as guides to be used in data analysis after the initial open codes emerge from the data: conditions, phenomena, context, intervening conditions,
actions/strategies, and consequences. These categories are used to describe the concepts. Thus, Glazer and others criticize Strauss and Corbin’s model as producing descriptive conceptualization rather than grounded theory (Kendall, 1999). However, a chief advantage of Strauss and Corbin’s model is that it is more highly prescriptive, and therefore more easily learned, and standardized for a team approach to cross-validating coding.

**Measures**

The qualitative design chosen for this study utilized two instruments: A semistructured questionnaire designed by the researcher, “The F2M Family and Work Questionnaire,” and a short-answer demographic questionnaire. Interview questions were developed based on a review of the literature related to the coming out processes for sexual minorities and for the transgendered. Qualitative inquiry traditionally employs a strategy of beginning with global questions in order to best access the interviewee’s perspective, meaning and nuance (Strauss, 1996). More specific questions may then be asked that evolve directly from the response to initial global questions. Additionally, as data is gathered through cumulative interviews, gaps in information may also dictate new questions.
Semi-Structured Interview:

"The F2M Family and Work Interview Questionnaire"

Interviewer’s instructions to the Participant: “As you already know, over the next hour and a half, I’m going to ask you a few open-ended questions about your experience of coming-out to your family and to your employer and co-workers, which will be audiotaped. Please feel free to answer as fully as you are able to. Following these questions, I will ask you several more specific questions relevant to the broader ones you have already responded to, for the purposes of clarification and to be sure I have understood you correctly.

You may, of course, decline to answer any question, for any reason. However, with your permission, I would like to be able to ask you for the reason you prefer not to respond. At the close of the questions, you may add anything I haven’t asked you, that you feel you would like to add, or that you feel is relevant to this exploration of coming out.”

The goal of these interviews is for me to gain as thorough and in depth an understanding as possible of what it is like for transitioning F2Ms to come out to significant people in their lives. For the purpose of this research, the term “coming out” refers to the process of letting your gender identity and decision to transition be known. Coming out encompasses all the thoughts, feelings, behaviors, interactions and events associated with that process. “Family” refers to your family-of-origin, including parents, siblings, grandparents and extended family or significant others with whom you spent your childhood. “Workplace” refers to your
place or places of employment, depending on the nature of your work.

"Coworkers" may include your employer, supervisor and colleagues with whom you interact on a daily bass.

1. General Overview
   
   Briefly describe yourself in a few sentences.
   
   Describe your family of origin  (Interviewer drew a modest Genogram)
   
   Describe your work situation in a few sentences.

2. Open-Ended Questions
   
   Tell me the story of your coming out as female-to-male to your family.
   
   Tell me the story of your coming out as a female-to-male at work.
   
   If you were a student, tell me the story if coming out at school.
   
   Tell me about coming out to your friends.
   
   How would you describe your quality of life before, during and after coming-out?

3. Previous Coming Out Experience
   
   If you came out as lesbian, what was that experience like as compared to this one.

IV. Quality of Life Issues
   
   Tell me about the physical and emotional changes you experienced.
   
   Have your feelings about yourself changed in any way as compared to before transitioning?
Describe your sexual orientation before, during, and after your transition.

Tell me about your spirituality before, during and after your transition.

Is there anything we have not discussed that is important for me to know?

_F2M Demographic Questionnaire_

(a) Age

(b) Place of birth

(c) Racial and Ethnic origins

(d) Religious affiliation

(e) Marital status

(f) Highest level of education

(g) Current place of residence

(h) Type and length of current employment

(i) Previous employment situations, if different

(j) Income

(k) Parents’ highest levels of education

(l) Parents’ income level

(m) Number and ages of brothers and sisters

(n) If parents are deceased, when did they die

(o) If parents live in a different geographic area, approximately how many miles away from your current residence do they live

(p) What sex are you

(q) What gender are you
(r) At what age were you first aware of your gender difference

(s) At what age did you decide to come out

(t) How old were you when you came out to your parents

(u) How old were you, and how long were you at your place of employment when you came out at work

(v) What are the approximate dates you’re your surgeries

(w) Do you participate in an FTM support group

(x) Did/do you use the internet as a means of support during transition

(y) Are you currently in psychotherapy, or have you ever been in therapy. If so, for what and for how long?

(z) Did your parents participate in family therapy related to your coming out process

Procedures

Subjects were mailed consent forms prior to the date of the interview, and returned signed copies of consent forms in self-addressed, stamped envelopes provided by the primary investigator. Consent forms explained the purpose of the research, as well as the procedures, benefits and any potential liabilities inherent in participating in a one and a half hour audiotaped interview (Appendix A).

Interviews were conducted in the homes of the participants. Interviewer and interviewee had paper and pencil at their disposal for note-taking, and a tape recorder was placed on a nearby table. At the outset of the interview, confirmation
of the voluntary nature of participation was reiterated. Interview questions were held constant with regard to wording and order for each subject. A semistructured format was used for the purpose of eliciting richer and more elaborate content and detail than a structured format might allow. Hence, open-ended questions, such as "Tell me about your coming out to your family," which do not limit constraints placed on the interviewee, were asked. Following responses to open-ended questions, more structured questions were asked that were based on both review of the literature, as well as on informal discussions with female-to-male transsexuals who were not participants in this study.

At the conclusion of the interview, subjects were required to complete a brief demographic questionnaire included in the Method section. They were then given time for debriefing. Inquiry included the following questions: Are you feeling any discomfort or distress as a consequence of this interview? If the subject answers affirmatively, then questions b and c may be asked; (b) What would help or make an immediate difference; and (c) May I offer you a referral to a therapist?

Follow-up telephone calls or electronic mail appointments were scheduled at a mutually agreed upon time for the specific purpose of clarifying statements made in the interview. The investigator initiated the call or e-mail contact as agreed at the time of the interview.

Participants' identities were held confidential by assigning each interview and tape a number. All data was stored in a locked file cabinet when not in use. Participants were informed that the dissertation committee and up to four additional people would have access to the data, the names of whom would be provided upon
request. Noncommittee members included four professionals who were at least at the level of doctoral dissertation research in psychology, and one person who assisted with transcription of interviews. All transcription was, however, was done by the primary investigator.

Each transcript was read multiple times by the investigator for the purpose of identifying theme domains within the transcript. This process requires two sets of note-taking. The first are coding notes, which bracket areas with coding labels. The second set is known as “memoing notes” (Strauss, 1990, p. 111). These are an ongoing collection of the researcher’s impressions and thoughts regarding particular content that will ultimately contribute to theory building.

The transcripts were next read individually by each member of the research team, which included the primary investigator and three peer auditors who were at the doctoral level. Team members first engaged in individual coding of transcripts, and then met for group coding to engage in constant comparison of commonalities and divergences in themes, which served to uncover theory. This process, which is known as “triangulation,” produces convergence, and consequently, supports validity. Emergent patterns were repeatedly tested and refined through group consensus.

Final categorization allowed for domains, or sets, that were conceptually and empirically grounded in the data. Data that was consistently repeated within transcripts, as well as across transcripts, was assessed as indicative of “saturation” or completed domains of reliability (Strauss, 1996, p. 35). Finally, axial coding, as
defined by Strauss and Corbin (1990) was conducted to generate a mapping of relationships of the constructs, from which the theory was ultimately derived.
Possibly the most daunting of tasks for the qualitative researcher is the culling through of overabundant text and detail generated by narrative interviewing. Much as the photographer chooses the proper lens through which to objectify the subject, so the qualitative researcher must make multiple subjective decisions regarding frame and focus. In turn, this process of relegation to foreground or background forces the researcher to acknowledge those personal and political biases inherent in choices made. Identification and explication of researcher bias is therefore a crucial preface to the endeavor of writing qualitative results. Three apparent researcher biases emerged while examining the data on coming out as a female-to-male transsexual person.

The first bias inherent in this research was as follows. Just as the brave clinician must be authentically present and available to be inducted into the client’s system, the qualitative researcher must assume this privileged position of becoming part of the phenomenon of the person being observed. For, “the observed and observer are part of a scientific story that is being constructed, and the researcher is the privileged author in its construction” (White and Epston, 1990, p. 82). Consequently, this research was entered into with neither the attitude of the voyeur
nor designed as an expose. It began from a stated position of respect and admiration for the existential courage implicit in the lives and words of each interviewee.

The second bias inherent in this research was that whatever predominant patterns emerged regarding the developmental process, no matter how challenging, these patterns would be framed as normative, nonpathological phenomena. This political bias is predicated on a growing body of literature cited in the review of this study, arguing for multiple, separate developmental models for diverse groups of people, predicated on race, ethnicity, sexual orientation and gender. Therefore, a strong perceptual bias is maintained that the transsexed are different but equal to individuals born with congruent sex and gender. Although this researcher did not set out to interview only successfully transitioned individuals, those who volunteered their narratives were uniformly successful. While it may be the case that there exist pathological trajectories for female-to-male transsexed people, they were not specifically sought out, and are not accounted for in this research.

The third researcher bias is that beauty rests in the eye of the beholder. While many researchers define successful transition as the ability to love and work (Pafflin & Junge, 1998), satisfaction must actually be defined by those who own it. While love and work are primary elements of a good quality of life, the respondents in this research define it differently. Rather, each unremittingly defined satisfaction as having achieved congruency, in which their internal experience of Self as a gendered male now correctly matched what others responded to in their physical presentation. Ultimately, to experience oneself as a male and have that mirrored correctly by the world was a chief measure of satisfaction.
Qualitative research is therefore significantly different from quantified studies in that the investigator becomes integral to process and content through mutual interactive influence. Moreover, the presence of the qualitative researcher is made uniquely explicit, through the use of accounts written in the first person of these interactions (Wolcott, 2001). Consequently, it is important to note that the aforementioned biases were birthed before undertaking this formal research. They were formed as a result of rediscovering a friend with whom this author lost contact for several years.

Annie was a contained young woman who was the partner of a coworker. Memories of visits with the couple usually contained an image of Ann off in a corner of the room, organizing her tackle box in preparation for her next weekend fishing trip. She was known to have had a difficult childhood and adolescence, partly due to having come from a strict Mennonite family. She was blond, blue-eyed and generally thought of by all as a thoughtful and kind person who kept to herself.

Ten years after losing contact with Annie, and in need of an accountant to manage a growing clinical practice, the author was referred to a highly esteemed CPA. “Will,” as he preferred to be called, was a warm, portly, and outgoing man with a full beard, an assertive handshake, and a deep voice. He was blond and blue-eyed, and wore a colorful tie with fresh-water fish printed on it.

The author truly had no idea that this gentleman was Annie, until calmly, but out of the blue, Will revealed himself. And, as the friendship was renewed over the next year, he gradually disclosed the details of his earlier life, and of his passage
from female-to-male. Eventually, the author was introduced to a loosely formed community of transsexed men in the Philadelphia area. Avid reading about gender acquisition and expression ensued to better understand the challenges these individuals posed to the author’s notions and definitions of gender. And thus, this study, replete with biases, was born.

*Database sources and collection.* The database for this study was culled over a period of four months, during which flyers and electronic mail listings generated 11 volunteer participants who fit eligibility criteria. Each participant consented to provide medical documentation of their transition in the form of a letter signed by their physician, to complete a brief demographic questionnaire, and to engage in a semistructured interview consisting of open-ended questions regarding their transition. Interviews were conducted in respondents’ homes and audio-taped for later transcription. Approximately 18.5 hours of taping was generated. In addition to participant interviews and support group input, further data was gleaned from workshop attendance at “True Spirit,” the east coast national transgender conference of female-to-males, held in Washington, D.C. in February, 2002. The author maintained process notes by journaling throughout the study, as dictated by generally accepted qualitative methodology, as well as notes on discussions with Will, who served as “inside informer,” providing additional data sources for triangulation.
Data analysis and interpretation. Analysis and interpretation of data was begun by the primary investigator after the third interview was collected, and continued until the process was completed. Content analysis began with multiple readings of each transcription. Core areas of responses were categorized and coded, leading to identification of themes for both across-case and between-case similarities and differences. Diagrams of key processes were mapped. Finally, a team of five doctoral level researchers was formed, to cross-validate categories, codes and themes extrapolated from the transcripts. The validation team communicated by electronic mail and participated in two lengthy meetings to debate and finalize areas of agreement and disagreement.

Discussion of Findings

The research findings will be divided into three discrete sections: (a) demographic and descriptive findings; (b) analysis of findings; and (c) interpretation. In the first section, demographic variables are provided, which will speak to the delimitations of the generalizability of the results of this study to the general population of female-to-male transsexed. The following section provides descriptive summaries of responses to questions asked regarding coming out as transsexed to oneself, to one's family, and at work. Pseudonyms are substituted to maintain respondents' anonymity. Summaries to questions about experiences in psychological therapy and with the medical system are also included.
The second section is devoted to an analysis of the responses. For the purpose of clarity, analysis of cross case similarities and between case differences will be viewed through the frames of “before,” “during,” and ‘after’ transition. In the third section, interpretation is offered regarding psychosocial development, minority identity development and spiritual development in the trajectory from female-to-male, including implications that may be drawn for providing psychological services to transgendered individuals seeking sex reassignment.

**Demographics Findings**

The study sample consisted of 11 Caucasian female-to-male transsexual men, for whom sex status was ascertained by documented standards of care letters, provided by treating psychologists or physicians. A graphic table of demographic characteristics can be found in Appendix B. Respondent ages ranged from 27 to 43, with a mean of 34.6 years. Participants were recruited from Pennsylvania, New Jersey, Maryland and Massachusetts, with 2 of the 11 residing in rural areas.

All were well educated and employed full-time. Two participants had some college education, three had bachelor’s degrees, and six held master’s degrees. Professions represented included an academic archivist, a writing consultant, a mobile family therapist, a case manager for the mentally retarded, a videographer, a broadcaster, a programmer, an executive assistant administrator, a social work administrator, a pharmaceutical scientist, and a steel worker.
Three participants were single, one was engaged, and six had long-term partners, with one having been recently separated. All of the respondents’ partners were female. Two subjects were parents, one with a latency-age son, and another with a college-age daughter. Religious backgrounds of subjects varied as follows: Catholic (2), Christian (1), Jewish (2), Lutheran (3), Protestant (1), and 2 United Universalists, (one of whom is also a practicing Two-Spirit Cherokee). Of the Judeo-Christian denominations, Only the United Universalists report currently practicing their faith. Three live within 10 to 20 miles of their parents, three live within less than 10 miles, two live between 20 and 50 miles, and three live over 200 miles from their families of origin.

All subjects had been self-injecting testosterone under medical supervision for at least one year. Eight participants had completed all desired surgeries or had scheduled them by the time of this study. Three of those men had completed genital reconstruction, in addition to having a full hysterectomy and chest reconstruction. The remaining three respondents were in the process of saving money for anticipated surgeries not covered by their health insurances. Finally, all but one respondent had been in long-term psychotherapy (greater than 3 months), and one participated in a 3-month regime of limited standard of care treatment (12 sessions).
Descriptive Findings: Across Case and Between Case Review

Coming Out to Oneself

*Early childhood.* While transition for the 11 men interviewed in this study occurred between the second and third decades of life, for all but one, awareness of being differently gendered began in early childhood. Statements including “I knew since I was 4 years old,” “I always felt more male than female,” and “I was never really a girl” typify early childhood experiences.

The commonly understood developmental tasks of childhood prior to age 4 (Erikson, 1968) include the development of basic trust grounded in the mother-infant relationship, development of a sense of autonomy, or a confidence in one’s ability to negotiate the world, and increasing curiosity and initiative to act upon the world. For all but one participant, who acknowledges being told by his mother that there were bonding difficulties in infancy, the majority of respondents appear to have enjoyed success in mastering these developmental tasks. Any variances in gender expression were accommodated by parents by labeling these children “tomboys.” This appears to have been predicated on the children’s clothing, toy and activity preferences. “I absolutely detested wearing dresses...”; “Wearing dresses was a real battle...”; “I wanted a football uniform; not Barbies!” and “I was constantly being told ‘girls don’t do that’” were frequent recollections.

Upon reaching school age, however, teachers began challenging the children’s gender expressions. Noah specifically recalls a parent-teacher conference in which his parents were informed, “We have a problem. Your daughter behaves
and dresses like a boy. She thinks she *is* a boy and only socializes with them.” Like most others, he remembers teachers constantly telling him “girls don’t do that.” Many narratives echo Charles’s statement, “I was pretty insistent that I was a boy.” Those with brothers noted they were “much more macho than their brothers.” Also common were statements like, “I was a little boy…and girls were ‘icky,’ ” and “I was pretty aggressive; I picked a lot of fights.” Corey’s experience suggests the depth to which a child can actually believe he or she is the opposite gender. He states that as far back as he can remember he never knew he didn’t have a penis; “It never dawned on me.”

The alternative childhood response to gender difference was to comply with social standards of gender presentation by complying whenever possible. Kip recalls:

> I always played the role of a girl, but I was performing. I was very boy-identified at certain junctures of my childhood, and I was miserable being female … By day, in school, I was girl-identified.
> After school, I was a boy with a boy name.

Two particularly poignant statements summarize the childhood experiences of these transgendered youth. Sam, who as a preadolescent, was browsing through a parent’s library during a sleepover at a friend’s home, recalls “I read about it in a book when I was young. But it said that surgery was unsuccessful and I felt very, very sad.” Noah seemed to speak for most, summarizing “My life would have been so much better as a child if anyone would have had a clue.”
Nonetheless, 10 of the 11 participants described their early parent-child relationships as good, normal, "no problem," or unremarkable, and childhood friendships were also described as generally good by all. During this period, it appears that teachers and other adults in the larger community were sources of friction, with parents coming to their child’s defense.

**Puberty and adolescence.** Despite the women’s liberation movement, Title IX’s promotion of growth in women’s sports, and the slowly growing acceptance of gay and lesbians in American society, almost all participants described adolescence as a uniformly traumatic experience as transgendered youth reaching puberty. It is here, in the teenage years, that achievement of the psychosocial task of developing a clear social role and gender-specific identity (Erickson, 1968) can become a defeating experience for the transgendered adolescent. Several informants described a poignant confusion and dysphoria created by feelings of being betrayed by one’s own body, and the realization that the world was incapable of knowing the true self.

Corey recalls that when he started growing breasts he could not understand why he had to wear a shirt outside in the summer. Ultimately, according to Abe: “Once I hit puberty I knew there was nothing I could do about being female and tried to make the best of it. But it was hard.” For most, the start of menstruation was "a heartache" that confirmed they were “truly female.” Corey recalls, “My gender presentation was an issue the whole time, but I never knew I had an option to change it.”
Most major developmental theorists agree that adolescence is also the time that one engages in the process of separation and individuation from one’s family (Rutter & Rutter, 1993). Depending on the degree of enmeshment against which the adolescent must fight, adolescence often becomes a time of moderate to extreme parent-child conflict. Eight of the participants recalled only minor, incidental familial conflict during these years; however, three experienced volatile adolescences.

The impingement of two additional traumas during adolescence may account for the difference. These men, who are now all in long-term recovery, struggled with addiction. They believe, in retrospect, that their substance abuse served to dull the pain of gender dysphoria. However, each of these three men was also sexually abused as children. While they believe their substance abuse was connected to dulling the pained memories of molestation, they say their gender dysphoria predated the sexual abuse, and that they did not feel the sexual abuses were related in any way to their gender presentations. They do report, however, that it was first necessary to get sober and work through the sexual trauma before being able to address their gender dilemmas.

For one of these three men, the combined traumas of childhood sexual abuse and gender dysphoria, culminating in substance addiction, made puberty particularly disturbing. He reports, “it never dawned on me that periods were ‘part of being a woman.’ I always bled during the abuse, and so I believed my early periods were a form of flashback associated with post-traumatic stress disorder.”
When the developmental task of consolidating one's sexual identity and orientation presented itself, all but one respondent sought refuge in the lesbian community, identifying as lesbian, bisexual or "queer". According to Noah: "In adolescence it wasn't working with straight boys and I knew something was wrong. So I came out as lesbian. But that wasn't right either." Most knew they were only attracted to women, but as told by Jack, "At 15 I was dating straight girls. I never liked lesbians." Similarly, Corey states "Even though I was dyke-identified, I just didn't want to be bothered with women. I was pretty much butch but not really lesbian." Hence, by this age there seemed to be a clear distinction between sexual and gender identification.

Respondents who identified as bisexual or "queer" reported general dissatisfaction in sexual relationships with men and ultimately gravitated to the lesbian community. There, they report experiencing camaraderie and a viable alternative to "straight society." However, as they approached early adulthood and began to express a heightening of their masculinity, participants reported increasingly less commonality and support within the lesbian community. Several were ostracized as "being too male" and felt policed by the lesbian community for being perceived as "homophobic," and thus, "a traitor" to the women's cause. Thus, at this point in development, several respondents reported experiencing a winnowing of friendships.

Kip handled the adolescent sexual experience quite differently. Instead, he said he overcompensated for his feelings of incongruency by accentuating his gender expression of femininity:
At 15, I was straight, female-identified and I had a lot of boyfriends. I was very high-femme - almost exaggerated in adolescence. I didn’t hate my body or how I looked.”

However, he was also quick to add:

The girl part of me was into doing things for myself; the boy part was basically just looking at the girls.

*Early adulthood.* Interviewees described pretransition early adult life in moderately positive terms. All but one were gainfully employed in satisfying positions, and all had what they described as comfortable relationships with their immediate families and partners. Two bore children during this period of development and clearly state that they would not have traded the experience of being a parent for earlier transition. Ostensibly, the majority had therefore achieved the developmental task of intimacy over isolation (Erikson, 1968), by engaging in long-term, intense relationships both in their personal lives and in the world of work.

However, positive statements were uniformly countered with statements that fell into one of three categories. One set of responses is characterized by a feeling of “stuck-ness.” Examples of these statements include: “I didn’t understand myself … ;” “I didn’t understand my body or where I fit…;” “I was stagnating; I wasn’t growing…;” “I was stuck as a boy … in my ability to grow as a man;” “I got tired of living as a teenager,” and “I can’t say it was terrible but I just wanted to look like what I felt – a man.”
Other participants engaged in before and after transition comparisons of quality of life issues using terms of relative misery. David recalls, “I was never completely who I was even though I could present myself well.” And Noah’s statement seemed to sum this up well. He said: “From the outside I looked good, but I was emotionally miserable ... I found a way to be comfortable and miserable at the same time. It was a comforting misery.”

A third group of statements regarding this pre-transition period were decidedly negative. Many were behaviorally descriptive of that period. “It was hell ...;” “A void ...;” “It was horrible. Abysmal. I was a square peg in a round hole.” Michael was “compulsive ... a workaholic, working all the time to avoid myself ... I did everything I could to run away from the reality of who I was ... I sometimes smoked too much pot.” Finally, from Corey, who is recovering: “I was a drug addict. Not in life. Surviving, not living. It was really bad.”

The experience of gender dilemma-related depression, whether intermittent or longstanding, evolved as a common thread among narratives. Depression was often attributed to gender issues. Negative feelings toward one’s body were often identified as causal factors. “Horror” and “disgust” were not atypical descriptors when respondents discussed breasts and other secondary sexual characteristics. Having to live in a female body appeared to be a chief reason for an overall absence of joy.

Most dramatic is a recollection of the interviewee who was unable to sustain work during pre-transition early adulthood. He recalls having a violent temper, winding up in jail for 8 months and ultimately making a serious suicide attempt by
shooting himself in the solar plexus. He related his memory of going under anesthesia with a wish: He imagined that the surgeon might magically realize that the pain of his gender incongruity led to his attempt, and in so doing, perform chest reconstruction so that he might awaken as a man.

**Coming Out to Family Members**

The average age at which respondents in this study began their medical treatment was 32, with disclosure to family following initiation of hormone treatment by an average of 4 months. Disclosures were planfully executed with three interactive elements dictating the process: (a) self-care; (b) compassion for family members; and (c) timing. The decision about when to disclose varied. Jack and David chose to inform their parents prior to beginning medical treatment. Jack originally “did not feel the obligation or desire to inform his family at all.” He recalls strongly resisting disclosure, but eventually accepted his psychologist’s suggestion to break his isolation. Jack recognized that he and his mother had bonding difficulties since his birth. He said he remained a challenging child who grew to be pervasively angry throughout adolescence and young adulthood. Yet, Jack recalls:

She didn’t have too much of a problem with it. She said ‘Just be happy.’ I saw her yesterday. She actually sat next to me; feels comfortable with me now; isn’t afraid ... It’s good. She’s really only upset about the chest reconstruction and having to go through major
surgeries to transition. I told her it doesn’t feel like a choice; it has to get done.

David also “had the talk” with his mother prior to starting hormone treatment.

Talking to my family almost felt like any other normal conversations … just one in a series in my life. I knew my mother and dad and sister would support me. My mom says she knew when I was 4.

And I had told her I felt I wanted to be a boy when I was a kid. Dad took it quite well, too. My sister just has problems with the pronouns.

Consequently, both Jack and David’s families had the opportunity to participate in their adult children’s transition, with awareness of the evolving physical changes.

Michael, who was among the nine men who disclosed after beginning medical treatment, took his tendency to avoid conflict into account. Rather than spend less time with his family, on the advice of his psychologist, he began phoning and visiting more frequently than usual, in hopes of reinforcing an already close relationship. While his family was accustomed to his man-tailored choice of clothing, Michael’s deepening voice precipitated concern that he was suffering from a bronchial condition. He wanted to allay their concerns. However, his mother’s health status, combined with a pending spiritual trip to a shrine in “the old country,” led to a decision to delay disclosure to a time that both parents were well and rejuvenated. Although he anticipated “histrionics” from his mother, in fact, he received loving support similar to Jack’s experience.
Isaac and Theo each had a parent who was seriously ill and elected not to disclose their new identities even after initiating treatment. Theo states that he is comforted that his father knew and accepted the reality of Theo's gender identity because before dying he gave Theo much of his clothing and his much beloved fishing gear and toolbox. Theo has never openly discussed his transition with his mother either. However, she too, relates to him as a "son" by relying on him for home repairs and referring to him when speaking to others as "her kid," rather than her daughter.

Similarly, Isaac has not come out to his mother due to long-standing serious illness and concomitant depression. However, he considers telling her "a nonissue." His parents are divorced, and he has not had a close relationship with his mother for many years, and he has only rare contact with her. He has, however, received acceptance from his father, who volunteered financial support for anticipated surgeries.

*Disclosure Patterns and Accepting Responses*

The prevailing disclosure pattern in this sample of transsexual men was to disclose to family only after initiating medical treatment and transitioning in the workplace, or at least, ascertaining that their employment would not be jeopardized. Having thus disclosed to friends, coworkers and employers, the incongruence of living as a man in every context, except their families-of-origin, reportedly grew increasingly more difficult. Nonetheless, neither living through the anxiety of the
aforementioned disclosures, nor meeting with surprisingly positive support lessened fears of parental rejection. This held true even though the majority of men enjoyed good parent-child relationships prior to transition. While all, at some time, came out to their families, or were recognized as lesbian by late adolescence, only two report having parents who had significant struggles accepting their gay identities. Yet, all the men anticipated that gender transition would be substantially more difficult for their families to understand and accept than coming out as lesbians had been.

Most wanted “to save family for last” because it was universally described as the most stressful coming-out-talk. Noah recalls feeling “scared to death” to come out as gay. In fact, it was “awful” for him.

So, when I was transitioning, I couldn’t bring myself to tell my father. I had my Mom do it. I expected the worst, but it turned out that he already knew a guy from where he worked who had transitioned ... I think part of him taking it well was that he had a hard time having a daughter that acted like a son. If anything, I now feel like the son he secretly wanted. He loves my brother, but he was a nerdy kid.

For all, the very real fear of being disowned was inherent in coming out to parents as transsexual. Two men indicated that their families each knew of one male-to-female transsexual, and had made derogatory remarks about them in the past. On the opposite end of the spectrum was Michael’s family, who reluctantly accepted but came to love a partner of his who was male to female. Significant,
however, is that despite visibly apparent changes in their own children, no parent commented on their child’s physical changes beyond worries about respiratory infections because of deepening voices. Parents often worried that their children “seemed to be sick a lot,” but none indicated that they suspected anything else. Several respondents indicated that they were waiting for parents to open the door to communication, but none did. And so, each man had to find his own way and words to “step up to the plate.”

After much careful thought, Charles elected to email his parents based on two reasons. First, he would not need to obsess over whether or not a letter arrived. Second, he also wanted to afford his parents time and privacy to process their reactions without having to simultaneously consider his feelings. While he learned that, in fact, they were initially shocked, like so many other parents in this sample, they told Charles they wanted only for him to be happy. Charles described his father as “the best booster of confidence.” He, like several other fathers in the sample, told their children that they knew they didn’t make decisions lightly, and that they trusted the maturity and thoughtfulness that went into their children’s decisions.

Much to their relief, six of the eight men who made face-to-face disclosures were met with loving reassurances and sentiments similar to those of Charles’ parents: “We love you no matter what; all we want is your happiness.” If this is what you feel you need to do, we will support you.” The mothers of several men expressed disappointment at not having been available to be helpful following surgeries that had already occurred. Several volunteered to accompany their child to
the hospital for scheduled surgeries. Finally, there was a common theme of expressed concerns relating to any possibilities for potential long-term effects of hormone therapy.

None of the respondents observed their parents going through obvious observable discrete stages of adjustment, as suggested in the research conducted on the parents of gays and lesbians. Noah believes his mother went through some of the stages, but not in a linear fashion. He hypothesized that perhaps because he disclosed after his transition, he denied her the potential for bargaining or denial. Michael’s mother was supportive following disclosure. However, weeks later she appeared depressed, and marital issues surfaced for her that had been avoided for years. He wishes his parents had sought supportive therapy, but knew their Catholic beliefs precluded outside help. He was, however, proud of not feeling his “typical guilt” and was able to understand his transition was not the root of their problems, but rather, an old systemic stress that now forced other issues to the fore. Theo recalls his mother being ostensibly supportive, yet angry over everything to the exclusion of his gender expression, for almost two years before accepting his transition.

On the whole, however, all of these parents appeared to demonstrate resiliency and strong support for their children. Communications often evolved into role reversals, in which, like Michael, they reassured parents that “I would always be their child even though I couldn’t be their daughter anymore. In many ways I hadn’t been a ‘real’ daughter for most of our lives anyway … They’d already accepted they probably wouldn’t have grandchildren when I came out as a lesbian.
years ago.” However, despite supportive attitudes, name changes and gender pronouns appear to be an enduring challenge for most parents. Many respondents wondered aloud if “slips” in this area were a product of habit or an unconscious expression of resistance to the realities of transition.

**Coming out to grandmothers.** Two of the men discussed their experiences disclosing to their grandmothers. Jack’s grandmother died before his transition. However, he recalls that when he was 18, upon seeing a television show with a transsexed person, his grandmother remarked, “That’s going to happen to you.” He remembers that the statement was followed by her somewhat stinging laughter. Nonetheless, her awareness was comforting to him. Noah, who wanted to spare his 90-year-old grandmother from having to deal with his transition, had his mother inform her.

But she was observant and had figured things out. When my mother told her, she was fine with it! She’s the only one who has consistently used male pronouns from the start, without slipping. She tells me ‘what a handsome grandson she has.’ So sometimes, when I think it’s dementia, I ask her what year it is just to make sure.

**Rejecting reactions to disclosure.** By contrast, Abe and Kip, who were parents themselves, and whose parents played relatively active roles in their children’s lives, met with dramatically different reactions, replete with rejection and legal threats to their parenthood. Abe recalls: “My mother went off the deep end.”
When my ex-husband remarried, he tried to take me to court to get my daughter ... I remember what the papers said like a mantra ... ‘living in an open and notorious lesbian lifestyle detrimental to the minor child.’ I fought and won. But, my mother ... who was proud of her outspoken lesbian daughter who marched on the Pentagon for not allowing gays and lesbians in the military ... was outraged over my transsexuality and anonymously called Child Protective Services. The investigation led to loss of my clearance for the privilege of teaching children. I was placed in the central registry for seven years because during the investigation I told my kid to tell the truth, and she admitted to smoking pot. I went into debt over lawyers and psychological evaluations for my child again. In the end, the case was not founded on the basis of sexual orientation or gender identity issues. My mother still denies she called CPS. But when I read the report, I could tell she had because they were her speech patterns.

Abe withdrew from his parents, but ultimately worked out an agreement permitting them to see their grandchild. A year prior to this study, his mother had a serious fall and required long-term hospitalization during which he became the primary caregiver for her and for his father. He recalls that on the 10-year anniversary of his transition, his mother said: “Life is too short for this ... I’ve come to see that you are a very loving, caring person, and that you’ve been here for me in a way I never expected. Let’s move forward.” “Things are good now,” says Abe, “yet I’m still
scared because of the feeling of being kicked in the teeth leaves me waiting for the other shoe to drop.”

Kip initiated “the conversation” with his family 6 months after completing his physical transition, and giving up waiting for them to initiate.

I didn’t really know how they would respond, though I thought my grandmother would be okay. My role in the family was always the good one, the savior, the one who did well in school, went to college at age 17, had a Master’s degree by 21... I was always the good one, until transition. We had a functional working relationship, and I hoped I could still count on them for support with things like helping my child. I thought they could possibly disown me but didn’t think they would because of my child. But they really don’t know who I am outside of transition even though my mother and grandmother live only a few miles away. There is a lot of dysfunction and there’s never been a lot of open communication. My grandmother did call me a faggot when I was a female-identified lesbian.

When I came out F to M, it was so messy. One day I didn’t shave and wasn’t careful about how I dressed. My grandmother was concerned because an uncle had asked if I was sick because of my voice, and she noticed my skin breaking out, which was caused by the testosterone in the beginning, and urged me to see a dermatologist. I told my grandmother I’d been working as a man and she said, I don’t care... you’re always going to be a girl to me ....
My grandmother told my mother. A week later on Mother’s Day when we were all together, my mother asked, 'Where’s ?,’ naming my girl name, as if I weren’t in the room. No one gave me a Mother’s Day card. It was the first time, and it was a very big deal. After that, I didn’t let them see my son until we had a document notarized about what was okay, so my kid wouldn’t be negatively influenced by their attitudes.

Over time, Kip’s family has accommodated to his changes. His stepfather refers to him as “my son,” and his uncle calls him “his nephew,” while mother and grandmother appear to remain neutral using “kid” and grandchild.”

*Coming out to children.* Neither Abe nor Kip believe their children had any great difficulty with either the fact or experience of their transitions. In fact, Abe recalls that Sandra, who was much wanted, conceived by insemination, and much beloved, was the first person he told. She’d already been exposed to Abe’s community of gay and lesbian friends, and was a latency aged when Abe came out to her. Sandy had questions like “Will you still be my mommy?” Abe replied that he “would always be your mommy but I’m going to look more like a daddy”. He believes she had “very little trouble” accepting the changes. “So little, in fact, that, that Sandy innocently “outed” me at least once when he was a child,” laughed Abe.

Kip’s son, who is mentally gifted, was 5 and in kindergarten when Kip explained the transition to him.
He knows everything. He’s very clear. I told him everything … that I feel more like a boy inside than a girl. He used to call me ‘momma,’ then switched to ‘momma-daddy,’ and then to ‘daddy.’ But he’s very clear I’m always going to be his momma, and that now I’m his daddy, too. So, my son has called me daddy in front of his classmates and friends since he was 5.

Kip, who grew up in the same district and attended the same presidential blue-ribbon-winning school as his son, now serves on the Parent Advisory Council as the Home and School Representative. He is the class ‘Captain,’ and participates in all the fundraising and extracurricular activities. In fact, his son’s current librarian, for whom Kip volunteers, was Kip’s 9th-grade English teacher. “So, it’s been great for both my son and for me,” said Kip.

Coming out to siblings. Disclosure to sisters and brothers was reported as feeling equally as stressful as coming out to parents, surfacing concomitant fears of re-experiencing feelings of shame and being perceived as “a freak.” Early sibling reactions ranged from “[I always thought you were],” and “[it all makes sense],” to being seen as “diseased” and kept from nieces and nephews. In Charles’ case, his brother’s rejecting attitude toward transition led to a decision to stop his hormone therapy. He resumed therapy upon resolving these feelings. On the whole, by the time interviews were conducted for this study, the majority of siblings had adjusted to their new brothers’ sexual reassignment well enough to resume normal sibling
interaction. Michael, who told his brother before his parent reported that his relationship with his brother has grown closer.

In summary, despite tremendous apprehension based in fear of disownment, seven of the nine men who disclosed to family met with supportive responses from parents. Both participants who elected to withhold disclosure did so on the basis of compassion due to parents' medical status. Grandmothers and children reportedly had the easiest time of accepting transition, while sibling reactions were mixed. However, the two respondents who were themselves parents, did, in fact, meet with parental rejection and intense conflict upon revealing their sex reassignment. In both cases, families have come to accept their transsexed offspring.

*Coming Out at Work*

Anticipatory anxiety about coming out in the workplace was, by all accounts, a formidable obstacle to disclosure. In fact, coming out at work was repeatedly cited as the most significant reason for delaying decisions to transition. However, once made, response to hormone therapy dictated the window of time within which each man had to make his disclosure without arousing discomfort and suspicion in others. Each man proceeded with baited breath. Of the 11 respondents, only one, a union steelworker, met with significant resistance and discrimination at his place of employment.
Planned disclosures and responses to them. Several men who had close relationships with coworkers who were gay or lesbian chose to first come out to them. Wherever there was a direct and close working relationship with a supervisor or administrator, respondents chose to disclose to them. The Directors of Human Resources were always met with early in the process of disclosure for five reasons: (a) to present the intention to transition on the job; (b) to discuss the business’s policies and procedures regarding diversity; (c) to educate the Directors regarding what to anticipate; (d) to explore methods best suited to disseminating the information in the workplace; and (e) to manage any untoward employee reactions.

Finally, all respondents adopted a strategy of disclosing to the person who commanded the greatest respect and interpersonal influence in the workplace, regardless of title. This held true in all professions, including academia and the corporate world, as well as for Michael’s self-owned consulting business.

Illustrations. David assumed he would be the first transsexed employee at his pharmaceutical company. He remembers relaxing measurably upon learning from the Human Relations Director that only two months earlier, a male-to-female transsexed employee from a different department had transitioned at another campus.

They gave me respect and made transition on the job very easy for me. I think Personnel were more nervous dealing with me than I was with them ... Because they just wanted to do it right ... not infringe on anyone’s feelings or personalities. HR, my supervisor, my
colleagues in the department were all wonderful! They accepted who I was as a person … separated it from my work. They laid it out to co-workers that this is who I am now; that I’m here to work and that we all had a job to do … said there was no room for harassment … So they set the tone for the company.

Charles, who together with his director, composed a mass emailing to be sent to all employees at his broadcasting network, recalls his director calling to ask if Charles was ready for him to “hit send.” “Not two minutes after giving the go-ahead, I received emails from the Bureau Chief on down. Coworkers of both genders were congratulating me.” Sam, too, recalls people with whom he was “not really close” walk into his office to shake his hand and offer support.

Abe’s supervisor “shrugged” saying “I wondered when this was going to happen” and proceeded to approve the letter Abe wrote to Personnel regarding his name and how he wished to be addressed. He recalls only a couple of employees “who weren’t receptive.” It was clear to him, however, that they didn’t wish to jeopardize their jobs, so they expressed distaste by trying to talk with him “about God.”

Corey was already accepted as “one of the guys” before transitioning. When he later changed jobs to work as a mental health technician for the developmentally disabled, the only impact being transsexual had was that he was not permitted to work with female patients because of same-sex regulations in assignments.

Kip, who has a Master’s degree in social work, handled transition quite differently. He decided that transitioning at his place of employment would be very
difficult for all involved. He opted to resign and accept a position as a full-time social worker to a patient with severe mental health illness who required 24-hour, in-home clinical supervision. “I didn’t think I could keep a regular job looking half boy and half girl ... and, only half of my documentation was changed to male status. I don’t think anyone’s particularly hirable then”. Kip is now the director of a social service program where he is “out.” The vitae he used for his job search contained both female and male pronouns, reflecting his transition. However, no mention was made of this during interviews. He reports, “I came out to my boss fifteen months after I started working there. I think they knew something was up.” He believes “a lot of people feel a different energy with a transman, but don’t know exactly what it is that they are experiencing. It can be uncomfortable. So I came out there.”

Noah, who was laid off following a successful transition on a job due to the business going bankrupt, had the unique experience of going on job interviews at the sexually ambiguous stage of transition. In retrospect he now believes it was “the best litmus test” for finding a good employer.

The changes were happening so quickly that I would send in my resume, talk on the phone, and by the time I came in for the interview, my voice had dropped several notches. So it had to have been incredibly confusing for the interviewers. But the reactions I got I was not prepared for. I went with a temp agency that told me over the phone that my qualifications looked great and that there were tons of jobs. My voice dropped about 3 days later, and when I went in for the position, not only did they not believe I was the
person they talked to on the phone, but suddenly there were absolutely no jobs anywhere. It was pretty obvious.

Noah was interviewing for administrative positions. One woman avoided shaking his hand at the end of an interview. Another, upon seeing Noah, mouthed to her secretary “I’m not in if that’s her,” after which he “bounded after her to the elevator, and introduced himself as her one o’clock appointment.”

His worst, and most colorful experience interviewing was with a nonprofit foundation, that by all accounts, was a perfect fit between its needs and his skills, and looked as though it were “in the bag.” However, after the interview, another coordinator, who was a gay man, privately cornered him and began asking illegal questions regarding his age and sexual orientation. After a wait of several days, he received a call. This is his recollection:

**HR Person:** “We’d like to offer you the job, however, we’re concerned about one thing, and that is your professional attire.” Noah wore a suit to both of the interviews and knew it was a casual environment where men wore sweaters. “I’m just wondering what you would wear.”

**Noah:** “I suppose dress pants and a nice collared shirt.”

**HR Person:** “Well let’s say we had a black tie affair. What would you wear?”

**Noah:** “Well, then I suppose that would be black tie! If you’re concerned about that, I do own a tuxedo. It does need
alterations, but if you anticipate a black-tie event next month, I’d be happy to do that.”

HR Person: “Fine. Are you interested in the job”?

Noah: “Great, yes. Please fax me a letter of confirmation with the salary and so forth.”

No fax ever arrived. They called a week later, again with concerns about his “attire,” and claimed they mailed his employment confirmation. He asked that it be faxed as well, as he had seen the advertisement for the position rerun after the time he was told he was hired.

Meanwhile, fortunately, Noah was offered, and accepted, the job of his dreams with an art institute and a major university, where he is now a respected and highly valued staff member. He did call the first agency to alert them that the coordinators he’d spoken with asked illegal questions both during and after the interview. Noah sees the greatest irony in that the agency generated funding for the visually impaired. All of its clients are blind.

Jack, who is a union steelworker in a small company “where nothing goes unnoticed,” also transitioned on the job. Jack took the female shop steward and the union president with him when he approached his employer. He recalls his boss “looking at him as if I were insane ... like he wanted to tear my head off.”

They’re taking the position that ‘if you are hired as a female, you will remain a female in our eyes.’ My feeling is. ‘Sorry! People get married, have kids, get divorced ... People change their status all the
time in our society.” They’ve already told me I can’t use the men’s room or the showers ... So I refuse to use the women’s room and I just hold it all day at work for almost a year. I’ve had to train my bladder. That’s how ridiculous the situation is...

Jack has engaged a union lawyer and is determined to have these issues resolved in his favor regardless of how long it takes. “I’m gonna stay even after I win. They’re going to have to learn to deal with it.”

Overall, coming out in the workplace was planfully executed after initiating testosterone therapy, and was met with a generally positive response in all but one case. The two most challenging elements of these disclosures were (a) anticipatory anxiety, and (b) having to secure employment while in the early stages of transition when one’s gender and sexual identity was most ambiguous, thus creating cognitive dissonance for others. Human resource departments were generally helpful in disseminating announcements that set a nondiscriminatory tone. In only one case, that of the unionized steelworker, was there evidence of overt discrimination in the workplace requiring legal intervention.

Coming Out and the Psychotherapy Experience

Odds are, if you experience yourself as transgendered, the legacy you’re left with is one of being poorly treated by people throughout your life. I really do think it’s hard to get through all of these changes and such a profound transformation without therapy (Noah).
Getting the therapy, however, was not always easy for the respondents. Even those who had been in therapy in their younger years for depression, recovery from sexual abuse or substance abuse indicated that they “spent hundreds of dollars in unsuccessful attempts” to bring themselves to say aloud that they felt more like men than women. Charles asked himself repeatedly, “Do I really want to tell this person I’m a man”? Those like Abe, who did brave speaking their realities aloud, felt cut to the quick by therapist assumptions that they were merely homophobic. Others such as Corey, were told that feeling transgendered only meant that “the fog hadn’t lifted” and they weren’t yet in full recovery.

There appeared to be two possible avenues to accessing a therapist to treat gender identity issues. Using the trial and error method, three of the men felt they “lucked out” by happening on therapists who were knowledgeable about GID, or who were gay or lesbian and sensitive to issues of diversity, if not the specifics of the psychological and medical processes of becoming transsexual. The second group researched specialists in GID through listserves and support groups. Only Charles reported seeing a therapist who was transsexual. He recalls feeling as if he were “being recruited,” and overwhelmed by an immediate onslaught of details regarding legalities documentation. The predominant feeling of each of the respondents was that “regardless of the sex, gender, sexual orientation or clinical background of the therapist, the fit of the relationship is everything.”

Helpful therapist interventions. Once a good fit between client and therapist was found, a broad range of general to specific interventions were identified with
two main areas of focus. Michael’s comments regarding negotiating coming out to friends, family and co-workers were echoed in many interviews.

Therapy helped me to separate the facts from my fears and anxieties.
It helped me to anticipate, strategize ... to think objectively and dispassionately ... to determine what I could control from what I couldn’t.

Michael also found directive suggestions like spending more time rather than less with his family to be especially helpful. Several spoke eloquently about how they worked hard to ‘undo the self-hatred and disgust for their bodies.’

Corey, who was in therapy for a post-traumatic stress disorder precipitated by sexual abuse, had a unique therapy experience. He lived in a rural area and was unaware of the option of sex reassignment. His therapist presumed he was a “bio-man” until the unfolding of his narrative indicated “he” was biologically female. The discovery led to the therapist’s second wrong assumption that he was already using hormone therapy because he was so clearly masculine. In fact, he had not, and it was his therapist who provided Corey with a psychoeducation about the spectrum of gender expression and experience, and of the medical advances currently available to those in his situation.

Lastly, most helpful to Jack was that his therapist “didn’t start out doubting that I had Gender Identity Disorder. She met me where I was, rather than making me “prove” myself as others had.”
Critiques of therapy for the transgendered. The resounding criticism made by respondents was that they, and other transmen they knew, all felt that psychologists and psychiatrists were overfunctioning in their roles as “gatekeepers.” Because the Harry Benjamin International Gender Identity Disorder Association’s Standards of Care required that anyone contemplating sex reassignment be approved by two mental health professionals to receive clinic services, the transgendered individual feels as if he or she is at the mercy of the mental health professional. In other words, the notion that a strange mental health professional can better determine whether or not one is transgendered than the individuals themselves was highly disputed in all of the narratives. Most seemed to feel that professionals were not really screening for severe mental health issues that might interfere with successful transition, but rather for whether the individual was “really” a transgendered person.

The results of this study suggest that candidates seeking approval for medical gender reassignment frequently express resentment at having to conform with the current standards of care. While the Harry Benjamin Gender Identity Dysphoria Association’s Standards of Care were originally designed to help those appropriate for treatment to receive it, the delineations are now perceived by the transgendered as overzealous. First, the notion of being labeled “as ill” and requiring a psychiatric diagnosis is experienced as offensive, particularly because being differently gendered is only problematic because of sociocultural strictures. Moreover, despite that transsexed people represent the same diversity of sexual preferences as society at large, many professionals have reportedly barred
candidates from transition on the basis of a potentially postsurgical homosexual orientation. Consequently, some candidates are reluctant to reveal any preference other than a heterosexual orientation.

In summary, although difficult to access, gender sensitive therapy was overwhelmingly described as essential to the transition process, but not for the reasons suggested by the body of regulators who established the standards of care for initiating sex reassignment. Rather, therapy helped reverse the damages caused by growing up feeling as if one were a male while living in a biologically female body. It provided psychoeducation, development of relationship and problem-solving skills, and generally offered a supportive relationship within which problems specific to transition could be explored and resolved.

Coming Out to the Medical System

Abe's statement best sums up the experiences with the medical system. "It depends on what and where ... Everything from absolutely outstanding to absolutely horrible." Those individuals who were able to access the transcommunity for referrals received generally good treatment. Those in rural areas experienced more difficulties. According to Jack:

No one would help me. I had to educate all of my doctors myself. They all said "We don't know what to do for you." So I contacted HBIGIDA, which was all the way on the west coast for names of local experienced physicians.
Physicians affiliated with metropolitan teaching hospitals were most knowledgeable about sex reassignment. Many respondents indicated that they were their doctors’ first transgendered patients. However, the general consensus was that general practitioners, gynecologists, endocrinologists, and surgeons alike were highly professional and sensitive, nonjudging and nonrejecting.

Conversely, a resounding complaint was that regardless of their physician’s professionalism, nurses and technicians were experienced as unprepared for providing services to the transgendered or ambiguously gendered patient. Abe recalls:

At the dinky little hospital where I went for surgery, a number of the nursing staff were really uncomfortable, and weren’t really sure what was going on. I’d only been on testosterone for two months, and I wasn’t looking very male yet. I hadn’t legally changed my name as female-to-male yet. So they were looking at a female who was presenting as masculine. And they were extremely uncomfortable.

Insurance coverage presented major problems for many, requiring that the majority of reassignment treatments be paid “out-of-pocket.” Noah explains:

All insurance companies have a clause denying coverage to anything directly or indirectly associated with transsexuality, reassignment treatment and surgical costs. This is wrong. It makes it seem as if we’re committing insurance fraud by attempting to get medical treatments covered by our insurances.
Kip, for instance, was turned away by several surgeons because his hysterectomy was not covered. When he finally found a surgeon willing to do the surgery, the ethics board of the Catholic hospital with which the doctor was affiliated, refused permission to perform the procedure. Ultimately, though, Kip recounts this experience following his hysterectomy:

Let me tell you ... I was in pain, catheterized, it was the middle of the night, and this woman in a white coat walks in. A tall, beautiful, blonde surgical resident comes into my room in the middle of the night and starts talking to me. And it's a transwoman!!! ... who's been interviewed on Nightline and other programs! And she said, "I just had to come up and see you!" Here I am on morphine and I'm thinking *Oh my God, it's a Trans-Angel!!!*

Each of the 11 subjects were in various stages of transition. Three had not yet had chest reconstruction. The remaining eight expressed universal satisfaction with their surgical outcomes. Some have not elected to have genital reconstruction, although they leave the possibility open for a time when substantial medical and surgical advances are achieved. Consequently, a commonly expressed concern regarded worries about the need for future hospitalization or surgery for any possible presenting problem. All shared the distinct fear of finding themselves in a medically compromised situation, in which they would not be able to advocate for themselves as patients. Two specific fears were noted. First, all were aware that insurance might deny coverage for medically necessary procedures on the basis of their history as transsexed individuals. Second, they feared they could receive
disrespectful treatment by nurses or technicians in whose care they might be, and suffer neglect, abuses or humiliation predicated on lack of education or outright discrimination.

**Summary of Descriptive Findings.** Narrative responses to semistructured interviews revealed that while each individual's experience of becoming visible to family, friends and coworkers was unique, patterns emerged for each category. While family members were generally the last to be informed, responses of parents, grandparents and siblings were largely positive. The two subjects, who were themselves parents, did encounter negative reactions from family. Their own children, however, made good and early adjustments to their parents' transitions.

Coming out at work was also experienced as positive for all but one man. The contention and discrimination that he met with may possibly be attributable to the culture of the steel industry in which he is employed.

Professionalism on the part of physicians in all disciplines of medicine was adjudged by the respondents as consistently good. Conversely, the quality of experiences with caregivers in the technical and nursing professions was less satisfactory. Finally, findings specific to therapy experiences were mixed, the details of which are addressed in the implications section of this research.
A second level of analysis of the descriptive database was made possible by the temporal frame of “before,” “during” and “after transition” was imposed by the structure of the original interview questions. These phased responses created a template, generating two psychological trajectories: intrapsychic and interpersonal, illustrated in Appendix C.

The intrapsychic trajectory subsumes movement from relative positions of inauthenticity that are based in confused sexual and gender identities, to authenticity through the consolidation of sexual and gender identity. The second trajectory reflects interpersonal movement from relative positions of social immaturity, lack of belonging and undeveloped spiritual lives, to maturity, connectedness and spiritual development. It should be noted that the differentiation between these two developmental lives is artificially drawn for the purpose of data analysis and the convenience of reporting. They naturally occur as interdependent phenomena.

The two core categories of intrapsychic and interpersonal developmental lines that emerged through analysis were found to be most consistent the Adlerian Theory of personality development, which are accounts for both the internal world
and social interface between individual and community. While a full explication of
Adler’s Theory is beyond the scope of this study, relevant fundamental concepts are
provided as under girding for the extrapolated analysis.

Phase I: Meaning-Making - Intrapsychic Development

First among the basic concepts in Adlerian psychology is the notion that
children form an impression of themselves and of life through early experiences
both within and outside of the family. A second basic Adlerian tenet is that
individuals strive for significance in life because of feelings of inferiority grounded
in those early childhood experiences (Marcus & Rosenberg, 1998). According to
Adler, exaggerated inferiority may be caused by a variety of experiences involving
the physical, intellectual, psychological, social or economic realm. Physical feelings
of inferiority may stem from organ deficiency, handicaps, abnormal height or
weight, or weakness. Intellectual inferiority may be rooted in such things as
illiteracy, skill deficiency or learning disabilities. Psychological inferiority is
understood as originating from feelings of being disliked, hated, or ostracized, and
shame. Social inferiorities generally stem from isolation caused by the child’s
interpretation of responses to their differences in areas of race, ethnicity, or gender,
and may result in social awkwardness. Finally, economic inferiority is seen as
emerging from experiences of family job loss or inability to generate adequate
income, or general impoverishment (Stein & Edwards, 1998).
While none of the 11 respondents reported experiencing intellectual or economic stresses in childhood, the descriptive findings do support that living in a female-sexed body was in some way experienced as a physical deficiency or handicap. For many, others’ perceptions of them as “female” resulted in feelings of wrongness about their bodies, and subsequent feelings of distaste and shame toward their breasts and other female secondary sexual characteristics. Shame was further embedded by some parents’ and teacher’s attempts to redirect children’s male-identified toy and clothing preferences toward more female-identified interests. Given that another of Adler’s observations was that our culture devalued women, these combined experiences of being perceived as female-gendered perpetuated feelings of awkwardness, frustration, and often, anger.

Hence, for the men in this study, the combined social and psychological imperatives to “live as if” one were a girl consequently resulted in an inauthentic way of being in the world. In turn, inauthenticity created ruptures in their ability to truly connect with the social community. If one is not seen for whom one truly is, invisibility precludes being able to belong.

Thus, in Adlerian terms, regardless of how loving and strong the parent child-bond, or how great or numerous the child’s developmental achievements, feelings of inferiority would necessarily be engendered by incongruency between one’s biologically determined sex and felt-experience of being a boy or a girl. Adler (1992) would have labeled the combined results of living-as-if a “minus situation.”
Adolescence further engendered “minus situations” or feelings of inferiority, with the realities of the onset of menstruation, dating and sexual orientation confusion presented by their transgender experience. By late adolescence, 9 of the 11 respondents made a final attempt at accommodating these feelings of differentness by connecting with a lesbian community and adopting a lesbian lifestyle. Each found that available identities, such as “bisexual,” “lesbian,” “dyke,” “butch,” and “stone-butch” were inadequate labels for defining their internal experience. This disidentification, or “not-me” experience was simultaneously occurring along with the acute awareness of their inability to mature into manhood. This specific desire, to mature into a man, presented a critical juncture at which their identity as transsexual was solidified on an intrapsychic level.

Nonetheless, and in keeping with Adlerian Theory, these minus-situations were concomitantly functioning to gradually move each respondent toward a creative, meaning-making “plus-situation” of transition and sexual reassignment. According to Adler, this teleological “creative power of life expresses itself in the striving after a goal and, in this striving, every bodily and psychological movement is made to cooperate” (Ansbacher & Ansbacher, 1956). Reflections of respondents’ experiences follow:

It was a really tough period just before. A process of ‘am I or am I not;’ … can I live with this? It’s gut wrenching. Torture. A bad place to have to be…and I’m glad I’m not there anymore. Once I figured
out I was transsexual everything clicked into place and I couldn’t go back.

Thus, each man was confronted by an existential dilemma. When the inability to mature into adult manhood became painfully apparent, each man found himself faced with the crises of aloneness and anxiety inherent in living as-if. In order to achieve the imagined “plus situation,” or idealized self, he had to summon the courage to face the reality that there was a choice: a choice between remaining alone and dysphoric, or of taking responsibility for his own happiness and desired heightened quality of life by becoming visible through coming out. “I felt like the moment I realized this, it was bigger that I was at that point” (Sam). Each knew the inherent potential for exchanging the anxiety and aloneness of gender identity dysphoria, for anxiety and aloneness that might be inherent in the stigma associated with sex reassignment. “It was a very scary time ... like going over a waterfall or snowballing ... picking up momentum.” Nonetheless, each made a conscious choice to reorganize himself and his life to achieve his goal, and to take responsibility for his own well-being. Only one man in the group talked about his feelings of sadness and loss, related to the decision to transition:

I had a Bon Voyage party. It was about going on a journey. I was nervous about it ... thought it would end up ‘a wake.’ There was definitely a lot of mourning about losing that female part of myself. It was like someone dying.
Phase 2: Action Taking - Interpersonal Development

The existential stage of coming out to oneself is next followed by a pragmatic action-taking stage, involving seven apparent tasks: (a) Making the commitment to educate oneself about the stepwise process of having one’s sex reassigned; (b) accessing knowledgeable and affordable psychological and endocrinology services; (c) initiating psychotherapy to meet standard of care requirements; (d) initiating hormone treatment; (e) pronouncing oneself male through a series of disclosures to significant others in one’s world, or “coming out;” (f) enduring the discomfort of sexual ambiguity during the early phases of hormone treatment while scheduling reconstruction surgery or accumulating financial reservoirs to do so; and (g) negotiating the regulations and legalities involved in permanently changing one’s legal identity, including such things as birth certificate, driver’s license, insurances and financial concerns. The speed with which this is accomplished largely depends on one’s reservoirs of psychic energy and financial resources, because both are highly taxed through this passage. However, once the original commitment was made, all of the respondents had completed this process within approximately 9 months of making their decision.

Phase 3: Arrival - Early to Mid-Transition

The physical experience. The power of this phase is best expressed through five of the respondents’ personal recollections.
I remember carrying out my first vial of testosterone ... holding it up and thinking, this is my manhood; With the first shot of Testosterone, I started to feel complete elation; It feels electric. Like somebody hooked an electric socket to my leg; Finally, a feeling of moving forward ... a feeling of progression; Like I had something to live for ... Myself.

Although a narrative description of “the first shot” was not specifically elicited by the interview, these men seemed to feel compelled to try and explain both their physical and affective experiences. The joy of making this milestone was most remarkable. Strikingly surprising to all is the universal experience of extremely heightened sexual desire, which is apparently becalmed to a “normal level” within a few months of initiating hormone treatment. Many explained the experience as “a second adolescence” or “trans-adolescence.” An overall sense of happiness was reportedly quite sustained and endured throughout the first year of transition, and well after.

The emotional experience. Several interviewees engaged in debate about discriminating between whether this sense of well-being is attributable to the physiological effects of testosterone, or to the psychological effects of having made the decision to transition. While that is impossible to deduce, all agree that the experience of congruency between soma and psyche is the achievement of what Adler would call the “final goal.” The number and frequency of unambiguously positive statements used by the respondents to describe quality of life after
transitioning speaks to the powerful therapeutic effects of combining psychotherapy and hormone treatment.

I’m more confident; calmer; I have better self-esteem; It gave me a feeling of greater strength; I have better ego-boundaries now; I’m not depressed; I don’t have the same social anxiety anymore; I’m not angry all the time anymore; The emotional benefits come from being a whole person; I enjoy being in my body; I’m so much healthier … I eat well, exercise; It’s allowed me to stand up for myself; People ask ‘Is he on Prozac? I want what he’s on;’ I’m like a kid in a candy shop… the world is open to me for the first time; I’m grateful to have more choices; One gift is I was given a sex life; I’ve had a sexual awakening; I have a job, a girlfriend, a stable and happy life – I’m a success; Life is so much better now … Sooooooooo much better; I’ve become who I am and who I always felt myself to be; It’s a new life.

Many acknowledged that these feelings of empowerment enabled them to summon the necessary courage to engage in the multiple disclosures inherent in this phase of becoming visible as men.

On sexuality. A not uncommon experience during the proposed third phase of transition was an evaluation of one’s sexual identity. Fantasy life intensified with the onset of hormonal surges, which for some men generated a surprising new fascination with homoerotic sex. Four of the men reported feeling disturbed by the experience. Their original dream was not to become gay as a result of sex
reassignment, but rather to finally be with a woman as a man. Three of the men reported engaging in brief experimentation, but found the experience “disappointing.” Each of them is currently in what they describe as satisfying heterosexual relationships, and now attribute the former phase to a heightened curiosity about male sexuality and a need to understand themselves as sexual men. However, one of these four men recognizes that he “probably always has been a gay man,” and is delighted that transition brought him to an understanding of his sexuality. Interestingly, however, he has not yet come out to his parents as gay, out of compassion for extent of adjustment they have already undergone.

Phase 4: Spirituality - Integration of Intrapsychic, Interpersonal, and Physical Gains

Chief among Adler’s central concepts is Gemeinschaftsgefühl, or “the feeling of community” (Ansbacher & Ansbacher, 1956). This social sense may be seen as an amalgamation of a cognitive understanding of interdependence between people, cooperative other-directed behavior, and an affective appreciation for both the comforts and discomforts of life (Stein, 2001). Adler envisioned connection and the feeling of community as a series of ever-widening, interdependent circles radiating around the self, encompassing family, friends, coworkers, the community, the nation, the world, and the cosmos (Stein, 2001).

Modern psychologists and philosophers might also define Gemeinschaftsgefühl as a spiritual phenomenon and a healing that may evolve as a
result of finding resolution to existential dilemmas such as aloneness and anxiety. Regardless of label, it is a post-transition experience shared by all of the respondents in this study.

My experience transitioning has restored my faith in people; Transition has you really exploring the inherent worth of human beings and humanity ... it has made me a more open, spiritual being; I used to expend so much energy keeping everything tied down...coming out has freed up so much energy; I can almost literally see ... I was so self-focusing. And now, I find I’m a lot more about what other people need ... like I’ve cleared out the closet and I’ve got this whole empty space to give people ... and it’s great; Being able to give back is a great feeling; I don’t have to worry about me anymore ... it isn’t all about me.

New Challenges

Respondents made very few equivocal comments about post-transition experiences. The steelworker who continues to deal with on-the-job discrimination issues has been labeled “the transman” at work, and admits to feeling determined but, at times, tired of having to be an activist. Several others are experiencing some stress due to attempts to accumulate enough money to complete their surgeries, because their health insurances will not cover the procedures. Lastly, John commented: “I think it’s harder for me since I transitioned because I’m so much
more tuned in to what’s important to me than before ... that I am respected as a man. Before it didn’t matter. Quite clear, however, is a joint feeling of both pride and responsibility. Each of the respondents is currently either mentoring a transgendered person who is coming out, participating in a support group, or providing some form of community or academic diversity training.”

Comparative Findings

In June of 2002, Holly Devor presented the first stage model of transsexual identity formation to the 6th Congress of the European Federation of Sexology, held in Limussol, Cyprus, the findings of which will be published in Volume 7 of The Journal of Gay and Lesbian Psychiatry (in press). The first model she proposed (Devor, 1997), which incorporates attendant characteristics and actions, has been unchanged since the presentation, and is offered in Appendix E. Devor’s model parallels extent social constructionist models for gay, lesbian and black identity formation detailed in the literature review of this study (Carrion & Locke, 1997; Meyers & Speight et al., 1991; Cross, 1971). Tailoring the model to the complexities of transsexual identity formation has led to 14 subdivisions, twice as many as Cass’s (1979) classic, empirically tested stage model of sexual identity development discussed earlier in the literature review. A map of Cass’s model is provided in Appendix E.

A summary of Devor’s model is as follows. Stage 1, “Abiding Anxiety,” is seen as a time of unfocused gender and sexual discomfort, during which the
transgendered person begins to prefer the other gender’s activities and companionship. “Identity Confusion,” or Stage 2, is when the first doubts about the suitability of one’s assigned gender and sex emerge. In Stage 3, “Identity Comparison,” one begins seeking and evaluating alternative gender identities through experimentation. “Discovery of Transexuality,” Stage 4, occurs when one has accidental contact with information indicating that transsexualism exists. Devor sees “Identity Confusion” as reappearing in a fifth stage, during which one doubts the authenticity of actually being transsexual. Stage 6, or “Identity Comparison,” is a testing phase when one begins to disidentify with women and females, and begin identifying as transsexed. “Identity Tolerance” is the seventh stage during which one identifies as “probably transsexual.” Stage 8, or “Delay,” marks a period of reality testing of one’s transsexual identity against intimate relationships and waiting or looking for confirmation.

“Acceptance” is achieved in Stage 9, when one begins to disclose to others. Stage 10 next marks a second delay before transitioning, during which support systems are organized. Not until Stage 11 are the medical and social gender and sex reassignments completed, followed by Stage 12, the establishment of post-transition identity. Upon “Integration,” in Stage 13, transsexuality is mostly invisible and involves some amount of stigma management. The 14th and final stage of “Pride,” is characterized by one’s being openly transsexed and advocating for transsexual rights.

The narratives generated in this concurrent study appear to be largely consistent with the findings of Devor, and those of Cass, upon whose model
Devor's was based. All of the proposed stage characteristics and actions were evidenced in content analysis. However, while they are largely confirmatory, some differences do emerge. The men in this study reported that they experienced deepening of their transidentity and disidentification with their biologically determined sex before, rather than after telling others about their transidentity. Upon "learning how to do transition" (Devor's Stage 10), hormone treatment was initiated (Devor's Stage 11), at which time they told others (Devor's Stage 9). For these men, stigma management and identity integration became necessary as early as Stage 10, as opposed to Stage 13, because the stage of sexual ambiguity was brief.

These are, nonetheless, minor variances. It does appear that Devor's Stages 1 through 4 (Anxiety, Confusion, Comparison and Discovery) correspond in a linear fashion with the first developmental phase of Meaning Making. Stages 5 through 8, (Comparison, Confusion, Delay and Tolerance) correspond with Phase II, or the Interpersonal Action-taking Phase. Devor's Stages 9 through 11, (Acceptance, Delay and Transition), correspond with Developmental Phase III of Arrival, and that Stages 12, 13 and 14, (Acceptance, Transition and Pride) parallel the final developmental integrative Phase IV of this study. An illustration of these correspondences may be found in Appendix D.
Limitations of the Study and Suggestions for Future Research

Simply put, the voices of 11 transsexed men cannot speak for the entire community of female-to-male transsexuals. Several significant groups are not represented in this convenience sample: Transsexed people of color, individuals aged 28 and under, and 45 years and older. The sample was further limited to men living on the mid-Atlantic and New England seaboard, although one respondent lived in Texas until a few years prior to being interviewed. Only two live in rural areas. All were educated, happily employed and enjoyed functional relationships with their families of origin. Only two were parents themselves. Consequently, conclusions drawn from this research cannot be generalized to the experiences of all female-to-male transsexuals.

Further study is therefore indicated for each of the above-mentioned groups. For instance, this researcher is aware of a number of transsexed men of color in the Philadelphia area. None voluntarily responded to participate in the study. Important information might be gleaned from specifically soliciting their perspective and reasoning for opting to not volunteer for research. Transmen living in other geographic areas, including more southern, conservative and rural areas, may encounter greater prejudice during the coming out processes, thus increasing the possibility for psychological trauma. Studying such a subject pool might reveal a lower percentage of transgendered individuals willing to engage in the transition and disclosure process, and less positive outcomes for those who do. Statistical
analysis of geographical locations represented by transmen attending national conferences may provide a starting point for understanding the impact of geosociopolitical influences on the coming out process. One wonders, also, about the impact of the Internet on accessibility of information, and the ability to come out. This sample was comprised of well-educated and middle-income participants, who were economically and intellectually able to avail themselves of current research and resources. Many participants in this sample met their expenses by paying “out-of-pocket” for their psychological and medical treatment. The plight of the transgendered in lower socio-economic groups, who are without medical insurance, or may not have access to computers, is assumed to be quite different.

This sample further excluded the growing number of people below the age of 28, including adolescents, who are now appealing for sex reassignment in greater and greater numbers. There exists great debate within the medical community regarding the advantages and disadvantages of allowing youth to transition. The multiple and complex overlay of developmental tasks, physiological changes and social stigma may be used to argue for both supporting early transition and for its delay. The clinical provisos suggested by this study are not generalizable to a younger population. A great deal of research is warranted with regard to best practice standards of care for counseling youth and their families about sex reassignment.

Specific religious influences particular to family of origin have not been examined. Faith-based parental attitudes may also play a far greater role in the
decision to transition and the process of coming out for transgendered people born into orthodox sects of their religions.

During the course of this study this researcher was also acquainted with a transsexed man who was wheelchair bound, a transsexed man living with AIDS, and one who was classified as mentally retarded, and living under the supervision of a nonprofit organization. The transsexed community encompasses issues of difference and diversity, as do all communities, and in turn, would benefit from research specific to these special-needs groups.
Implications for Therapy

While one certainly cannot generalize the results of this study to the population of all female-to-male transsexuals, it is also possible that the insights of this group of men may be generalizable to some individuals of different geographic, racial, ethnic, sociocultural and psychological circumstances. The following conclusions are offered for consideration by the clinician called upon to provide psychological services to transgendered women seeking sexual reassignment as men.

Therapist education. First among the findings is the recommendation that the uninitiated clinician educate himself or herself about the vicissitudes of gender development and sexual reassignment in order to provide accurate and adequate psychoeducation. While clinicians must always be prepared to learn from their clients, knowledge of relevant local resources is a critical aspect of work with transsexed clients. Awareness of local support groups, state laws, Internet resources and medical providers is strongly urged by the respondents in this study.

Therapist bias. If, after gaining education regarding transgender issues and examining one's personal biases, one's clinical role is still perceived as that of
"Gatekeeper," referral to a gender specialist may be indicated. In fact, the results of this study suggest that the gatekeeper function is contraindicated when (a) the presenting problem is clearly stated as Gender Identity Disorder (GID), (b) is accompanied by an explicit interest or desire for sex reassignment, and (c) psychological testing results do not indicate significant psychiatric disorders classified as contraindications to transition (i.e. acute suicidality, psychosis or severe personality disorder). In this case the clinician's job is not one of determining whether or not the client is transsexual, but rather, what conditions are necessary to promote the fulfillment of the client's goal of reassignment.

For instance, when the client presents as lesbian, with what appears to be GID, but without stated interest in reassignment, homophobia should not be assumed. Rather, a thorough evaluation is suggested, with particular attention paid to the level and extent of the client's awareness of options. It is likely that psychoeducation will help the client to clarify her or his position. This research suggests that posing a question such as "Have you ever felt more like a man inside a woman's body, than like a woman?" is unlikely to prompt an individual to iatrogenically become a candidate for sex reassignment. It may, however, allow an opening for a transgendered person to finally speak aloud his or her thoughts, feelings, questions and concerns for the first time.

Client evaluation. Research supports that the felt-experience of gender and sex begins at birth, and is socialized and acculturated throughout one's life. Respondents in this study had implicit and, for some, explicit awareness of feeling
transgendered as early as age 4. Therefore, issues of self-esteem, uneven social
development, depression and anxiety may be seen as normative therapeutic targets
of treatment, rather than conditions for ruling a client out for sex reassignment,
unless psychological testing results indicate acute instability. Both intrapsychic
issues and, those that evolved as a result of cultural and social stigma, and
stereotype threats need to be kept in simultaneous focus in order to best formulate
case conceptualizations. Shame, in particular, appears to be a key contributor to
symptoms, with body image issues at the core. And, despite the level of
self-loathing that was frequently revealed in these narratives, it may be important to
guide clients through exploration of issues of loss parts of one’s female identity.
Clients seem to defend against these existing feelings for fear that if they are
revealed, the therapist will not support their wish to have their sex reassigned.

Client-therapist relationships. Finally, therapy may be the transclient’s first
ture experience of having his internal world mirrored and, in turn, the first authentic
experience of therapeutic collaboration with the self (Kohut, 1959). The many
comments in these narratives related to “goodness of fit” between client and
therapist, clearly indicate that providing this mirroring for the previously invisible
maleself is fundamental to ameliorating shame, depression and anxiety, and to
engendering the courage necessary to transition.

Lessons on Coming Out to Family and Friends
Family. This study suggests that despite high levels of anticipatory anxiety, when the parent-child relationship has been relatively stable and of good quality, a positive and supportive parental response is quite possible. More negative parental reactions may be associated with disclosures made by individuals for whom there were acknowledged bonding difficulties in early childhood, or who are parents, as there is natural concern for the impact on one’s grandchildren, as well.

Planful disclosure does not have to be face-to-face. Client’s instincts on deciding how and when to disclose were reliable in this study. Use of email and phone contact resulted in equally successful experiences. Moreover, client decisions to not disclose are not necessarily grounded in fears of rejection, as presumed by some therapists, but rather, in compassionate knowledge of a parent’s capacity to receive information due to their physical or psychological health histories.

Disclosing to parents had positive outcomes for all 11 participants. Parents’ acceptance and support may be a significant factor in promoting healing of the narcissistic bruises imposed by years of silence and social stigma. In this study, mothers frequently wish to be helpful to their adult child, in providing post-operative support. Sibling relationships must also be explored, as they were found to be a source of support.

Respondents did not observe discrete stages of mourning in their parent’s reactions to disclosure. This may be due to the pattern of disclosing to parents last, when transition was a fait accompli. There was, however, a subtle aftermath in some family systems. Some men reported changes in family dynamics evidenced by marital stress or a parent beginning to uncharacteristically displace anger onto
others. Respondents' chief expressed disappointment was their family members' continuing accidental use of female pronouns and their former female name. Because a parent's instinct is to protect a child, it is possible and likely that the parents had greater difficulty accepting their child's transition than they revealed. Family therapy is therefore recommended if and when possible, after disclosure has been made.

*Disclosing to friends.* Friends were frequently cited as the first and easiest to disclose to, with one proviso. It is not uncommon for a transgendered person who is lesbian-identified or affiliated with the lesbian community to encounter negative reactions from other lesbian women. Politically oriented lesbian friends were found to perceive transition and sexual reassignment as a political affront to their lesbian sensibilities. Respondents expressed a full range of feelings, including sadness, shock and hurt, related to this occasional political shunning.

*Lessons on Coming out at Work*

The narratives of these men suggest that when planning disclosures in the workplace, it may be important to consider the nature of their work. Academia, nonprofit entities and corporate businesses do appear to wish to accommodate for issues of diversity, and respect state and national discrimination policies. Cooperation and consultation services from directors of human resource departments may be anticipated. All of the human resource directors in this study
set and supported a no-nonsense nondiscriminatory tone. This was handled so effectively that when given the option, no respondent elected to have any business-wide on-site diversity trainings. This does not preclude the value of diversity training for employees, which have been found to be helpful on a case-by-case basis. Last but not least, if available, access to a unisex, private bathroom in the workplace was ideally recommended by most respondents. Where unavailable, clients should be encouraged to explicitly discuss potential problems in this area with their human resources representative.

*Final Thoughts*

On first reading, the coming out experiences of these men may appear unrealistically rosy. One might wonder if so much positive acceptance on the part of family, friends and coworkers might be a function of socioeconomics, education or other demographic variables. In fact, these men were all well-educated and from the middleclass. One might also wonder if the narratives were somehow biased or colored by the respondents’ need to prettify their experiences. Rather, the predominantly good reception that each man received is hypothesized as being a function of two phenomena: (a) that of attachment and intimacy in relationships, and (b) the societal impact of power associated with gender.

These narratives may possibly suggest that a secure attachment between parent and child acts as a significant buffer, or “protective factor” against the
world-at-large, (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969, 1988), enabling female-to-male transgendered children to fare relatively well with family and friends. It was not until children became school-age that teachers, with whom the children were less intimate, brought negative public attention to their gender expression. Moreover, very little strum and stress was evidenced in parent-child relationships during the adolescent separation and individuation stage. For these men, family appears to have been the safe harbor against the hormonal storms within their bodies, and in the world outside the home. Perhaps parents’ intuitive knowledge, early on, of their children’s differences, combined with awareness that the outside world may be less kind or tolerant, afforded significant protection. Perhaps, despite that their parents could not mirror their child’s felt-gender, the bond provided approval and a strong enough sense of self to negotiate the world. Further research is therefore suggested to explore parents’ conscious and semi-conscious awareness of children’s differences and the impact of that awareness on child development and resiliency.

All of the people to whom the participants disclosed were individuals with whom they already had well-established relationships. Perhaps loving, caring about or simply knowing the transgendered person who is disclosing precludes the feared rejection. In fact, experiences with the medical system appear to bare this hypothesis out. Treating physicians, with whom the participants had on-going relationships, provided respectful and sensitive care. Conversely, during hospitalizations, nurses with whom participants had no previous relationship, were experienced as far less sensitive and, at times, callous or disrespectful. It would
seem to follow, therefore, that the farther out one moves across the social circles from intimacy, to acquaintance, to superficial contacts with strangers, tolerance diminishes. However, within one’s more intimate relationships, acceptance may, indeed, be more likely than not.

Finally, the relative ease of transition reported by the female-to-male transsexed participants in this study is also hypothesized as being a function of the power of male and female gender-status in our culture. The history of the feminist movement underscores the veracity of the observations made by Adler in the beginning of the 20th century regarding the devaluing of the female in our society. Transition from female-to-male would therefore imply a heightening of social and personal power, and thus, a heightening of self esteem. Conversely, male-to-female transsexed people, upon whom the general public’s impressions of sex reassignment are typically made, involves loss of social value. Thus, it is not surprising that the vector from female-to-male is more easily traversed, because it leads toward cultural affirmation. To the critical reader, such positive outcomes may appear questionable. Nonetheless, they are the experience of the author who has had the honor of following many transman in their journeys. Other clinicians in the treatment community, as well as a leading researcher in the field, also concur that, optimism is warranted in embarking on transition with female-to-male clients.

For those clinicians who are able to embrace diversity, and disengage from the standard sociocultural binary notions of gender, working with the female-to-male transsexed client can be an odyssey of enormous learnings. Being present for and with a person who steps directly into the existential,
meaning-making business of life by facing and taking responsibility for who they are and what life has presented them with is among the most rewarding experiences a therapist encounters. It seems not unlike being a midwife to the client who is birthing himself. And it is no surprise that on the average, the people in this study completed formal transition within nine months.

The mysteries of sex and gender can become powerfully seductive and distracting for the clinician engaging in case formulation and treatment planning for clients seeking support in their coming out process as female-to-male. While sex and gender are each important defining elements of identity, the voices of the men in this study must serve as a reminder that the sum of a person is greater than his or her physical and psychological parts. Clinicians must take care to view sex and gender as inseparable from the context of the individual life within which each is uniquely rooted and constructed.
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Appendix A

Consent to Participate

PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE

4190 CITY AVENUE, PHILADELPHIA, PENNSYLVANIA 19131 - 1693

DEPARTMENT OF PSYCHOLOGY
215-871-6442
215-871-6458 FAX
psyd@pcom.edu E-MAIL

INFORMED CONSENT FORM

TITLE OF STUDY

Becoming visible: A qualitative analysis of female-to-male transsexuals' coming-out experiences.

PURPOSE

The purpose of this research is to find out about the experiences of female-to-male transsexual individuals while coming out to their families, friends, employers and their co-workers. It is hoped that the findings of this study will help to educate mental health professionals about the normal experiences encountered during coming-out and lead to improved and culturally sensitive counseling for transgendered people seeking support for coming out as transsexual.

You are being asked to be in this research study because you have volunteered to participate as a result of hearing about the study in a support group or through an electronic list-serve of which you are a member. If you are under the age of 21, or have not yet acquired the letter of approval from a mental health professional that the Harry Benjamin Gender Identity Disorder Association requires for starting transition treatment, or you are not already receiving medically supervised testosterone therapy, you can not be in this study. Please note, that surgery is not a requirement for eligibility as a participant of this study. A copy of your letter must be provided along with this consent form.
Appendix A

Consent to Participate

INVESTIGATORS

Responsible Investigator

Name: Emily R. Chernicoff, M.C.A.T.
Department: Psychology
Address: One Bala Avenue, Suite 216
         Bala Cynwyd, PA 19004
Phone: 610-664-9544

Principal Investigator

Name: Elizabeth A. Gosch, Ph.D.
Department: Psychology
Address: Philadelphia College of Osteopathic Medicine
         Rowland Hall, Suite 226
         4190 City Avenue
         Philadelphia, PA 19131-1693
Phone: 215-871-6509

The doctors and scientists at Philadelphia College of Osteopathic Medicine (PCOM) do research on diseases and new treatments. While this is not a study about disease, it may provide vital information to mental health professionals that will help to normalize transsexuality by increasing acceptance and understanding. This study may also help professionals to provide better supportive counseling services to individuals preparing for sexual reassignment. The interview you are being asked to volunteer for is part of a research project.

Even though the goal of this research project is to study the normal coming out process for female-to-male transsexual people, no one can say that this study will guarantee that all mental health professionals will see sex reassignment as an acceptable decision as a result of this study

If you have any questions about this research, you can call Dr. Elizabeth Gosch at (215) 871-6509.
Appendix A

Consent to Participate

If you have any questions or problems during the study, you can ask Emily Chernicoff, who will be available during the entire study. If you want to know more about Ms. Chernicoff or Dr. Gosch’s background, or the rights of research subjects, you can call Dr. John Simelaro, Chairperson, PCOM Institutional Review Board at (215) 871-6337.

DESCRIPTION OF THE PROCEDURES

You will be asked to participate in an interview conducted by Emily Chernicoff, at a time that is convenient for you, in your own home. If you would rather not be interviewed at home, the interview can be held in The Center for Brief Therapy, at the Philadelphia College of Osteopathic Medicine.

You can expect the meeting to last between 2 to 3 hours. When you arrive, Emily Chernicoff will review this consent form with you and answer any questions that arise since you first received it. This is to be sure that you understand that you may decide not to participate even if you have arrived for the scheduled interview. You may withdraw from this study simply by refusing to provide your consent, and by not proceeding with the interview. You will also be informed that you may refuse to answer any question asked during the interview, and that you may withdraw from the interview and withdraw consent to participate in the study altogether, at any point during or after the meeting. By signing this consent form, you are agreeing to proceed to the next step of the meeting, which is the interview.

You should be aware that the entire interview will be audio-taped. When the interview is finished, the tapes will be locked in a secure cabinet, and only be removed for the purpose of transcription. The person who will transcribe your tape will be required to sign a confidentiality form. You will be asked to pick any name you like that will be substituted for your real name when your interview is transcribed, so that we can protect your confidentiality. Any written information that will directly identify you will be kept in a locked cabinet.

Your interview will consist of general questions about your experiences coming out to your family, friends, employer and co-workers. The questions are "open-ended”, which means you will be asked to give more than a ‘yes’ or ‘no’ answer. Family can be understood to mean your parents or guardians, siblings and extended family with whom you live or lived prior to your transition. Since there are only 5 broad questions, you may give fairly long answers. The interviewer will also ask you some short questions to be sure what you are saying is clearly understood and that all of the answers are complete.
Appendix A

Consent to Participate

When the interview is finished you will be asked to fill out a brief short-answer questionnaire that may take about 10 to 15 minutes. At that time you will be asked what name, other than your real name, that you would like us to use for the study to protect your confidentiality. You will be asked to use that name on the questionnaire. That name will be written on the audio-tape, as well.

Before you leave, Emily Chernicoff will schedule an appointment time with you to have a brief phone or e-mail contact, so that she may ask any final questions necessary to fully understand your what you said in the interview.

POTENTIAL BENEFITS

You may benefit from being in this study because many people report that sharing their coming-out story helps them to have a clearer and stronger understanding about their choice to come out. However, you may not benefit from being in this study. Other people in the future may benefit from what the researchers learn from the study.

RISKS AND DISCOMFORTS

It is possible that during the course of the interview, or after the interview, you might experience some emotional upset. This may occur as a result of recalling life-experiences that were distressing during your coming-out process. Because of this possibility, you will be given the names and phone numbers of two mental health professionals that you can choose from for follow-up counseling.

ALTERNATIVES

The other choice is to not be in this study.

PAYMENT

You will not receive any payment for being in this study.

CONFIDENTIALITY

All information and medical records relating to your participation will be kept in a locked file. Only the research investigators and the members of the Institutional Review Board will be able to look at these records. If the results of this study are published, no names or other identifying information will be used.
Appendix A

Consent to Participate

**REASONS YOU MAY BE TAKEN OUT OF THE STUDY WITHOUT YOUR CONSENT**

If health conditions occur that would make staying in the study possibly dangerous to you, or if other conditions occur that would damage you or your health, Dr. Gosch or Emily Chernicoff and their associates may take you out of this study. In addition, the entire study may be stopped if dangerous risks or side effects occur in other people.

**NEW FINDINGS**

If any new information develops that may affect your willingness to stay in this study, you will be told about it.

**INJURY**

If you are injured as a result of this research study, you will be provided with immediate necessary medical care.

However, you will not be reimbursed for medical care or receive other payment. PCOM will not be responsible for any of your bills, including any routine medical care under this program or reimbursement for any side effects that may occur as a result of this program.

If you believe that you have suffered injury or illness in the course of this research, you should notify John Simelaro, D.O., Chairperson, PCOM Institutional Review Board at (215) 871-6337. A review by a committee will be arranged to determine if your injury or illness is a result of your being in this research. You should also contact Dr. Simelaro if you think that you have not been told enough about the risks, benefits, or other options, or that you are being pressured to stay in this study against your wishes.
Consent to Participate

**VOLUNTARY PARTICIPATION**

You may refuse to be in this study. You voluntarily consent to be in this study with the understanding of the known possible effects or hazards that might occur while you are in this study. Not all the possible effects of the study are known.

You may leave this study at any time. If you stop the interview due to feeling emotionally upset, you will be asked to contact one of the mental health professionals who provided you a letter of recommendation to begin your transition.

You also understand that if you drop out of this study, there will be no penalty or loss of benefits to which you are entitled.

I have had adequate time to read this form and I understand its contents. I have been given a copy for my personal records.

I agree to be in this research study.

Signature of Subject: ____________________________
Date: _____/_____/_______ Time: _________AM/PM

Signature of Witness: ________________________________
Date: _____/_____/_______ Time: _________AM/PM

Signature of Investigator: __________________________
Date: _____/_____/_______ Time: _________AM/PM
### Appendix B

**Participant Demographics**

<table>
<thead>
<tr>
<th>Pseudonym &amp; Relationship Status</th>
<th>Age</th>
<th>Religious Background</th>
<th>Highest Degree Earned</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABE Partnered</td>
<td>43</td>
<td>Lutheran</td>
<td>MA</td>
<td>Videographer</td>
</tr>
<tr>
<td>COREY Dating</td>
<td>28</td>
<td>Jewish</td>
<td>Some College</td>
<td>Mental Health Case Manager</td>
</tr>
<tr>
<td>ISSAC Engaged</td>
<td>27</td>
<td>Unitarian</td>
<td>MS</td>
<td>Academic Archivist</td>
</tr>
<tr>
<td>JOHN Partnered</td>
<td>35</td>
<td>Protestant</td>
<td>Some College</td>
<td>Union Steel Worker</td>
</tr>
<tr>
<td>MICHAEL Dating</td>
<td>33</td>
<td>Catholic</td>
<td>BA</td>
<td>Writing Consultant</td>
</tr>
<tr>
<td>KIP Partnered</td>
<td>33</td>
<td>Two-Spirit Cherokee &amp; Unitarian Universalist</td>
<td>MSW</td>
<td>Social Work Administrator</td>
</tr>
<tr>
<td>SAM Partnered</td>
<td>32</td>
<td>Methodist</td>
<td>MA</td>
<td>ITT Programmer</td>
</tr>
<tr>
<td>DAVID Partnered</td>
<td>40</td>
<td>Lutheran</td>
<td>BS</td>
<td>Pharmaceutical Scientist</td>
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<tr>
<td>THEO Single</td>
<td>41</td>
<td>Christian</td>
<td>MS</td>
<td>Mobile</td>
</tr>
<tr>
<td>NOAH Partnered</td>
<td>35</td>
<td>Jewish</td>
<td>BA</td>
<td>Administrator</td>
</tr>
<tr>
<td>CHARLES Dating</td>
<td>39</td>
<td>Catholic</td>
<td>BA</td>
<td>Broadcasting</td>
</tr>
</tbody>
</table>
IV. INTEGRATIVE PHASE

*Spirituality*
& *Gemeinschatsgefl*

- New-born faith in the world at large
- Mentoring others; Providing Training and Education
- Heightened openness and Other-Directedness
- Disclosure to Parents and Family of Origin
- Increased Physical and Libidinal Energy,
  Self-Care & Self-Esteem
- Surgeries Begun If Affordable

---

III. ARRIVAL PHASE

*Early to Mid-Transition*

- Disclosure to Children, Friends, Employer and Co-Workers
- Ambiguous presentation and adjustment
- Initiation of Hormone Therapy
- Disclosure to children
- Acquisition of Letters of Approval for Treatment
- Gender-Identity Specific Therapy
- Self-Education: Accessing Transgender Resources
- Decision-Making; Disclosure to Partner

---

II. INTERPERSONAL PHASE

*Action Taking*

- Self-exploration through psychotherapy
- Existential Dilemma: Am I transgendered/transsexual
- Contact with other transgendered people
- Further experience of incongruence: Increasing awareness through comparison of difference from Lesbian peer group
- Alignment with the Lesbian and feminist communities.

---

I. INTRAPSYCHIC PHASE

*Meaning-Making*

- Intensifying discomfort with body
- Adolescence: Socialization to 'live-as-if'
- hool: first negative attention to gender expressions by teachers
- Normal family and peer relations
- Beginning awareness of gender difference as early as age 4
- Good-enough early childhood parent-child bond
Appendix D

Devor’s Model of Transsexual Identity Formation.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Some Characteristics</th>
<th>Some Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Abiding Anxiety</td>
<td>Unfocussed gender and sex discomfort.</td>
<td>Preference for other gender activities and companionship.</td>
</tr>
<tr>
<td>2. Identity Confusion About Originally Assigned Gender and Sex</td>
<td>First doubts about suitability of originally assigned gender and sex.</td>
<td>Reactive gender and sex conforming activities.</td>
</tr>
<tr>
<td>3. Identity Comparisons About Originally Assigned Gender and Sex</td>
<td>Seeking and weighing alternative gender identities.</td>
<td>Experimenting with alternative gender consistent identities.</td>
</tr>
<tr>
<td>4. Discovery of Transsexualism</td>
<td>Learning that transsexualism exists.</td>
<td>Accidental contact with information about transsexualism.</td>
</tr>
<tr>
<td>5. Identity Confusion About Transsexualism</td>
<td>First doubts about the authenticity of own transsexualism.</td>
<td>Seeking more information about transsexualism.</td>
</tr>
<tr>
<td>7. Identity Tolerance of Transsexual Identity</td>
<td>Identify as probably transsexual.</td>
<td>Increasingly disidentify as originally assigned gender and sex.</td>
</tr>
</tbody>
</table>

Presentation to 6th Congress of the European Federation of Sexology
Limassol, Cyprus, June 19, 2002.
Appendix E

Correlation of Psychosocial Evolution of Female to Male Identity
With Devor's Model of Transsexual Identity Formation

I. INTRAPSYCHIC PHASE  
*Meaning-Making*

- Intensifying discomfort with body
- Adolescence: Socialization to 'live-as-if'
- School: first negative attention to gender expressions by teacher
- Normal family and peer relations
- Beginning awareness of gender difference as early as age 4
- Good-enough early childhood parent-child bond

II. INTERPERSONAL PHASE  
*Action Taking*

- Self-exploration through psychotherapy
- Existential Dilemma: Am I transgendered/transsexual
- Contact with other transgendered people
- Further experience of incongruence: Increasing awareness through comparison of difference from Lesbian peer group
- Alignment with the Lesbian and feminist communities

III. ARRIVAL PHASE  
*Early to Mid-Transition*

- Disclosure to Children, Friends, Employer and Co-Workers
- Ambiguous presentation and adjustment
- Initiation of Hormone Therapy
- Disclosure to children
- Acquisition of Letters of Approval for Treatment
- Gender-Identity Specific Therapy
- Self-Education: Accessing Transgender Resources
- Decision-Making; Disclosure to Partner

IV. INTEGRATIVE PHASE  
*Spirituality & Gemeinschaftsgefühl*

- Newborn faith in the world at large
- Mentoring others: Providing Training and Education
- Heightened openness and Other-Directedness
- Disclosure to Parents and Family of Origin
- Increased Physical and Libidinal Energy, Self-Care & Self-Esteem
- Surgeries Begun if Affordable

*Pride*
Appendix F

Cass's Model of Gay Sexual Identity Development (1979)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.  <em>Identity Confusion</em></td>
<td>Questioning the assumption about one’s sexual Orientation</td>
</tr>
<tr>
<td>II. <em>Identity Comparison</em></td>
<td>Feelings of isolation and alienation from both prior assumptions and heterosexuals.</td>
</tr>
<tr>
<td>III. <em>Identity Tolerance</em></td>
<td>Seeking out others of the same persuasion and tolerating a gay/lesbian identity.</td>
</tr>
<tr>
<td>IV. <em>Identity Acceptance</em></td>
<td>Selectively disclosing identity to others</td>
</tr>
<tr>
<td>V. <em>Identity Pride</em></td>
<td>Immersion in gay/lesbian culture and rejection of heterosexual values.</td>
</tr>
<tr>
<td>VI. <em>Identity Synthesis</em></td>
<td>Minority identity no longer an overriding identity; but rather an integrated aspect of self</td>
</tr>
</tbody>
</table>