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UNIVERSITY OF SAN DIEGO

Hahn School of Nursing and Health Science

DOCTOR OF PHILOSOPHY IN NURSING

Exploring the Lived Experience of Male-To-Female Transgender Youth Accessing
Trans-Related Healthcare in Los Angeles

By

Marcel Fomotar

A dissertation presented to the

FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE

UNIVERSITY OF SAN DIEGO

In partial fulfillment for the degree

DOCTOR OF PHILOSOPHY IN NURSING

April 2016

Dissertation Committee

Jane M. Georges, RN, PhD, Chairperson

Ann M. Mayo, RN, DNSc, FAAN Member

Nnenna Weathers, RN, PhD, Member

UNIVERSITY OF SAN DIEGO

Hahn School of Nursing and Health Science

DOCTOR OF PHILOSOPHY IN NURSING

CANDIDATE'S NAME: Marcel Fomotar

TITLE OF DISSERTATION: Exploring the Lived Experience of Male-To-Female Transgender Youth Accessing Trans-Related Healthcare in Los Angeles

DISSERTATION COMMITTEE:

Jane M. Georges, RN, PhD,
Chairperson

Ann Mayo, DNSc, RN, FAAN,
Committee Member

Nnenna Weathers, RN, PhD,
Committee Member

Abstract

Background: According to the National Institutes of Health (NIH) (2015), LGBTI individuals delay healthcare treatment because they fear stigmatization or because they believe many healthcare professionals lack knowledge and experience working with LGBTI individuals. The phenomenon of living as a transgender person and accessing trans-related healthcare is understudied.

Aim: To explore the perceived meaning of accessing transgender-related healthcare among transgender youth.

Method: A phenomenological qualitative design grounded on Husserl's descriptive phenomenology was used to explore the ascribed meaning associated to accessing trans-related healthcare services among transyouth as they experienced and perceived it. A purposive and thematic sample of Male-to-Female transyouth ages 21 to 24 years residing in Los Angeles California was obtained. Data was collected through digitally recorded one-on-one, face-to-face semi-structured interviews. Colaizzi's descriptive phenomenological strategy was used to integrate significant statements into principal themes.

Findings: Three major themes were identified: Transitioning, Self-Fulfillment, and Trans Community Solidarity. Transitioning was of utmost importance to the participants as it allowed them to live full and authentic lives, and trans community solidarity was important in mitigating the stigma faced by transyouth. Transitioning not only helped in aligning the participants' gender identities and physical bodies, but also in allowing others to see and interact with the participants in the ways that were consistent with how the participants saw themselves. Having access to trans-related healthcare assisted all

participants to be happy and comfortable in their female self. Accessing trans-related healthcare facilitated integration into the closely-knit trans community that served as a support system for the participants due to their shared experiences.

Conclusion: This study suggests that developing a trans person's sense of belonging to the trans community can be enhanced by helping them develop their transgender identity. This in turn potentially has the ability to improve mental health and thus quality of life for trans individuals. **Implication:** It is imperative that healthcare professionals and policy-makers recognize the significance and impact of transitioning and ensure timely and efficient access to trans-related healthcare resources for trans individuals.

Keywords: Transgender, transitioning

Copyright

Dedication

To Dr. Jane M. Georges, my mentor, and to the Transgender Community in Los Angeles who made this study possible.

Acknowledgement

First of all, I express profound and sincere thanks to everyone who in various ways contributed to the successful completion of this academic exercise. Particularly, I acknowledge the invaluable assistance and support of my dissertation committee members, Dr. Jane M. Georges, Dr. Ann M. Mayo, and Dr. Nnenna Weathers: Thank you all for being just the right team of mentors for me. I thank Dr. Joselyn Harris and Spencer for their mentorship as well.

I also heartily thank the entire community of the Hahn School of Nursing and Health Science of the University of San Diego; Susan Merrill, Cathleen Mumper, Dean Sally Brosz Hardin, Drs. Patricia Roth, Cynthia Connelly, Ruth Bush, Mary Barger, Mary-Rose Mueller, Lois Howland, Eileen K. Fry-Bowers, all my classmates especially Essie, Ginger, Valerie, Tammy, Mohammed, Julie, Teri, Kim, Mark, Monique, Vanessa, Vickie, Jodi, Kathy, Marissa, and Jian Hua, without whose unconditional support, I would not have completed the program.

I am forever thankful for my wife Michele, my kids Manu and Lanelle for making my journey worthwhile. I am equally grateful to my family and friends for providing me with the support I needed to go through the PhD program; Kila, Fola, Esthel, Steve, Mainsah Asheri, Caroline, and Yefon, Richard Tatah, Drs. Kimbo, Njei Basile, Christian Bime, Pascal Kingah, Amusa Ntatin, Munoh Foma, Adetola, Julius Ngwa, Mr. Blaise Che and family, Mr. Maison and family, Yuyun Terence, Erna Ngwayi, Syl Anim, BFU-USA, and my CAMSOLA team mates.

Lastly, and none the least, I shower nameless and endless praises and thanks to God my Creator and Driver. I fully accept responsibility for all the views expressed in

this work except where otherwise noted. I also regret for any apparent errors the reader may find in this work, which to the best of my knowledge are inadvertent.

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Chapter One

Introduction: Aim of the Study

The purpose of this chapter is to justify the need for inquiry into the lived experience of trans-youth accessing trans-related healthcare. A background to the study, assumptions informing this study, the specific aim, and a brief overview of methods will be discussed.

Background

The Institute of Medicine (IOM) report issued in March 2011 acknowledged a sparsity of existing evidence on Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) health, and recommended the need for substantial research. Meanwhile, LGBTI populations have higher prevalence rates for some health conditions than the general population according to data from recent studies and national health surveys (NIH, 2015). According to the National Institutes of Health (NIH) (2012), sufficient evidence exists showing that LGBTI individuals delay healthcare treatment because they fear stigmatization or because their experiences have led them to believe that many healthcare providers lack knowledge and experience working with LGBTI individuals. Given the high rates of such health conditions as HIV, suicide ideation and attempts, and substance abuse in these populations, the consequences of delayed care may increase morbidity and mortality. Even more concerning, is the evidence that delayed care is due to lack of knowledge and experience of healthcare providers in dealing with LGBTI individuals (Lim, Johnson, & Eliason, 2015). Researchers have found that LGBTI individuals receive healthcare services that are not as appropriate and effective as those provided to non-LGBTI individuals (Johnson, Mimiaga, & Bradford, 2008; King, Semlyen, Killaspy, Nazareth, &

Osborn, 2007; Lim et al., 2015; Martin & Meezan, 2003; Pizer, Sears, Mallory, & Hunter, 2011; Sevelius, Patouhas, Keatley, & Johnson, 2014).

Meanwhile, the NIH (2015) acknowledges that transgender health in general has not been a focus of specialized clinical care compared with gay and lesbian health, and attributes this to an even greater lack of data and resources. The IOM (2011) report also pointed out that research has been conducted unevenly among the LGBTI population, with more research on gay men and lesbians and less on bisexual and transgender individuals. Mayer, Makadon, & Garofalo (2008) argue that transgender individuals have had to struggle to have their clinical issues taken seriously and to find appropriate resources for care. Clearly, this population is at risk for health disparities. It must be noted that about 700,000 individuals in the United States identify as transgender (Gates, 2011). Under the weight of stigmatization, discrimination and marginalization, accessing healthcare is one of the major problems faced by the transgender population (Bauer & Hammond, 2015; De Santis, 2009; Fikar & Keith, 2004; Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Hoffman, Freeman, & Swann, 2009; Tanner et al., 2014).

The IOM (2011) report also pointed out that most research on the LGBTI population has focused on adults, with less on adolescents and few studies on LGBT elders. The 2014 special issue of the *American Journal of Public Health* delineated how social stigma affecting LGBT youths has resulted in a wide range of health disparities, ranging from increased prevalence of depression and substance use to downstream effects, such as an increased risk for cancer and cardiovascular disease when older (Mayer et al., 2014). The Healthy People 2020 initiative has a major commitment to reducing health disparities with a special emphasis on new emerging marginalized

populations (Koh, Piotrowski, Kumanyika, & Fielding, 2011). Therefore, understanding the range of health problems as well as the challenges to optimizing health and healthcare access among transgender youth in the U.S. is key if health and healthcare disparities are to be adequately addressed.

Transgender Identity and Heterosexism

The term “transgender” describes people who have gender identities, expressions, or behaviors not traditionally associated with their birth sex (Gender Education & Advocacy, 2001). Transgender people are often grouped by their gender vector which are male-to-female (MtF) and female-to-male (FtM)(Education, 2004). MtFs are people who have been assigned at birth a male gender but who identify their gender as female. FtMs are people who have been assigned at birth a female gender but who identify their gender as male. These two gender identities (MtF and FtM) have been widely used by transgender people and in the transgender literature (Kenagy, 2005). Although definitions of the term transgender itself are contested, “transgender” is coming to represent an umbrella term applied to anyone who bends the common societal constructions of gender, including cross-dressers, transsexuals, genderqueer youth, drag queens, and a host of other terms that people use to self-identify their gender (Stotzer, 2009). Stotzer (2009) argues that the term “transgender” is “gender neutral” in the sense that it includes both people born as males who express or identify their gender as female and people born female who express or identify their gender as male.

However, variations in the congruence between sex and gender do exist (Alegría, 2011). There is a difference between sex and gender with sex referring to natal sex (i.e. male, female, intersex) while gender refers to the psychological, social, and cultural

aspects of maleness and femaleness (Alegria, 2011; Kessler, 1978). Transgenderism refers to appearance, behavior, or identity that does not conform to socially constructed norms for women or men (Meyerowitz & Meyerowitz, 2009; Morgan & Stevens, 2012). Transgender persons may actually have sexual partners of any sex or gender. In addition, the range of transgender activity or identity varies widely. For example, transgender persons may choose to dress in cross-gender attire (i.e., not congruent with their natal sex) on occasion or full-time (Alegria, 2011). Further, the gender identity of persons who engage in transgender activity may be congruent with their natal sex. That is, engaging in cross-gender activity does not necessarily indicate cross-gender identification. Cross-gender activity may be pursued for activities of leisure or sexual variety (Meyerowitz & Meyerowitz, 2009). For example, a person born male who enjoys wearing women's clothing after a bad day at work may identify as a man, yet enjoy the relaxation that cross-dressing brings him. Clearly, the phenomenon of transgenderism is complex and thus warrants more in-depth studies for a better understanding of this population.

Meanwhile, transgender people face systematic oppression and devaluation as a result of social stigma attached to their gender nonconformity (Baral et al., 2013; Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Herbst et al., 2008; Lombardi, 2010; Lyons et al., 2015; Mayer et al., 2014; Nemoto, Sausa, Operario, & Keatley, 2006). Many transgender individuals report experiencing homophobia (the fear and dislike of lesbian and gay people) on the basis of their perceived sexual orientation (Bradford, Reisner, Honnold, & Xavier, 2013; Chapman et al., 2012; Hill & Willoughby, 2005). In a world dominated by heterosexuality, transgressing societal norms of gender seems to be the major reason for such negativity and mistreatment of transgender

individuals (Morgan & Stevens, 2012). Heterosexism is the belief that heterosexuality is the norm and that people can be presumed to be heterosexual (Chapman et al., 2012; King et al., 2007). The healthcare system in the U.S is shaped by both heterosexism and a lack of awareness of transgender people's lives and needs, which may consequently enforce social invisibility on LGBT families (Chapman et al., 2012; Couch et al., 2007; Neville & Henrickson, 2006). Social invisibility perpetuates stigma and shame and undermines a sense of the full meaning of life, morale and well-being for LGBT people (Weber, 2008). Transphobia, which is the fear and dislike of transgender people, has been shown to be a major barrier to receiving and providing quality healthcare to transgender persons (Chapman et al., 2012; Couch et al., 2007; Kattari & Hasche, 2015; Klitzman & Greenberg, 2002; Neville & Henrickson, 2006). Thus, given this evidence, further study is needed regarding transgendered persons' experiences in the U.S. healthcare system.

The consequences of such mistreatment (transphobia) are devastating and even more destabilizing particularly for the transgender youth who are at a psychosocial stage of development wherein identity crisis occurs. The vulnerability of this population necessitates a thorough investigation into its healthcare needs and experience. Homelessness, unemployment, prostitution, substance abuse, physical abuse/violence, suicide ideation and high rates of suicide attempts, high rates of HIV/AIDS and other sexually transmitted infections are some of the significant challenges with real consequences for the transgender youth population (Bauer & Hammond, 2015; Chapman et al., 2012; De Santis, 2009; Garofalo et al., 2006; Harawa & Bingham, 2009; Herbst et al., 2008; Hoffman et al., 2009; Ramirez-Valles, Garcia, Campbell, Diaz, & Heckathorn,

2008; Sausa, Keatley, & Operario, 2007; Sevelius, 2013; Snelgrove, Jasudavicius, Rowe, Head, & Bauer, 2012). Thus, documentation exists that shows that serious health issues in this population exist that require further study.

Clearly, the world of persons who identify as transgendered is very complex. Simply assuming transgendered people's lives as a community of individuals feeling like they are "in the wrong body" is incorrect. Their issues, identities and experiences are complex but worthy of the time, energy, patience, and caring it takes to learn about them (Morgan & Stevens, 2012).

Transgender Persons and Healthcare Access

According to Lombardi (2010), transgender people often have two different sets of healthcare providers: one involved with gender transition and one involved with regular healthcare visits. Many transgender people seek to align their outward physical sex with their internal gender identity through hormonal and surgical interventions. The goal of this treatment is to reduce, if not eliminate, the hormonally induced secondary sex characteristics or genitalia of the natal sex while inducing those of the core gender (Gooren, Giltay, & Bunck, 2008; Rotondi et al., 2013). Traditional healthcare plans (public and private) do not cover the costs related to changing one's gender, leaving people to find other ways to fund their transition from one gender to another (Lombardi, 2010). A high proportion of transgender people have taken hormones at some point in their lives without medical supervision (Sanchez, Sanchez, & Danoff, 2009). Some of the reasons for this potentially dangerous practice include the fact that their insurance plans would not cover the costs, or heightened levels of fear and mistrust experienced by those seeking care from healthcare providers (Rotondi et al., 2013). The insensitivities of

healthcare providers and poor past experience with health systems are the main reasons LGBT persons avoid or delay presenting at health agencies (Couch et al., 2007; Polek & Hardie, 2010). This creates a barrier to healthcare access for LGBT persons.

Access to healthcare remains a real challenge for transgender people. Healthcare access means empowerment of an individual to use healthcare. As a multidimensional concept, it is based on the interaction (or degree of fit) between healthcare systems and individuals, households, and communities (McIntyre, Thiede, & Birch, 2009).

Unfortunately, having health insurance does not necessarily translate into full healthcare access. Also, the availability of healthcare services does not always translate into utilization. Even more perplexing, the need/demand for and availability of healthcare services does not always mean the consumer receives culturally sensitive healthcare. The central issue therefore, is whether policy-makers, providers, and consumers of healthcare services take adequate steps to ensure that full healthcare access reflects the critical attributes of healthcare access that include availability, demand, and acceptability. Furthermore, variations in the meaning of the concept of healthcare access remains a challenge.

There is evidence suggesting that provider attitude toward clients is decisive in healthcare access especially within the context and reality of structural violence (e.g. heterosexism, racism, ageism, and classism) (Beach et al., 2005; Betancourt, Green, Carrillo, & Ananeh-Firempong 2nd, 2003; Kinsler, Wong, Sayles, Davis, & Cunningham, 2007; Majumdar, Browne, Roberts, & Carpio, 2004; Willging, Salvador, & Kano, 2006). There is also evidence that to varying degrees, patients' personal preferences, such as values, hopes, and fears, and other inherent psychological factors

have a bearing on the utilization of healthcare services (McFall & Yoder, 2012b).

Cultural acceptability of providers becomes even more relevant in this regard as, there may be a cultural mismatch between the healthcare provider and the patient, which can have a negative effect on healthcare access among vulnerable populations (Norris & Aiken, 2006). Apparently, many of these characteristics are value laden, and, as a result, preferences in treatment are often difficult to separate from a mistrust of the system and providers (McFall & Yoder, 2012b). The IOM (2011) report suggests that primary contributing factors to disparities in healthcare access include segregation and racial discrimination. Therefore, besides personal preferences and cultural beliefs, trust of the healthcare system and providers becomes very crucial.

A clear and shared understanding of what healthcare access means is relevant within the context of health and healthcare disparities. Full access to healthcare would mean appropriate utilization of healthcare services (Andersen, Davidson, & Baumeister, 2007; McFall & Yoder, 2012b; Norris & Aiken, 2006; Shengelia, Tandon, Adams, & Murray, 2005). Such access will most likely lead to decreased health and healthcare disparities, and improved healthcare outcomes or improved quality of life of an individual or a population such as the transgender population (McFall & Yoder, 2012b; Norris & Aiken, 2006).

Significance

The transgender youth population is vulnerable to healthcare inadequacies and requires tailored healthcare interventions and policies that are transgender-youth-specific and support a gender-based diversity perspective across social institutions. Understanding individual and contextual factors that affect access to healthcare is necessary. This study

produced preliminary pilot data by exploring transgender youth participants' lived experience with accessing trans-related healthcare. Thus, this study created a beginning knowledge base for developing and testing interventions designed to facilitate healthcare access and utilization.

Purpose Statement

The overall purpose of this study was to explore healthcare access among the transgender (trans) youth population ages 21-24. The following specific aim was addressed:

Explore the perceived meaning of accessing transgender-related healthcare

Research Question

What is the perceived meaning of accessing transgender-related healthcare in a group of trans youth ages 21-24?

Brief Overview of Research Design

A phenomenological qualitative design was used to explore the lived experience of trans youth accessing trans-related healthcare. The use of this approach was appropriate, as there is currently no documentation of the lived experience of the transgender young adult (21-24) population accessing trans-related healthcare. A purposive and thematic sample of MtF trans youth ages 21 to 24 residing in Los Angeles California was obtained. Data for this phenomenological study was collected through digitally recorded one-on-one, face-to-face semi-structured interviews. One-on-one interview methodology was appropriate to illicit feelings and personal experiences in the healthcare system. Following transcription, qualitative interview data was coded and

analyzed for themes. The descriptive phenomenological strategy developed by Colaizzi (1978) was used to integrate significant statements into principal themes.

Assumptions

The assumptions informing this phenomenological study were the following:

- 1) Trans youth are an underserved and understudied population
- 2) Trans individuals experience stigma and discrimination in healthcare.
- 3) Health disparities exist in trans youth due to heterosexism, homophobia, and transphobia.
- 4) Absence of a measurable and or operational definition for healthcare access is a cause for healthcare inadequacies affecting trans individuals.

Chapter Two

Literature Review

The purpose of this chapter is to review relevant literature in this study area. Prior research in the major study concepts of healthcare access, experiences in the healthcare system, and barriers and facilitators to healthcare among transgender individuals will be reviewed as a basis for this study. The philosophical underpinnings informing this phenomenological study will be described and the rationale for choosing a phenomenological approach will be explicated.

Healthcare Access

Healthcare access is an important concept in health policy and health services research. However, due to variations in the meaning of the concept, a precise definition remains a challenge. Understanding the concept within the context of health disparities is particularly necessary at this time in the history of the United States' health system with the passage of the Patient Protection and Affordable Care Act ("Obamacare") in 2010 that seeks improved healthcare access across all populations (Hall, 2013; Krugman, 2010). The idea of improving healthcare access is also an acknowledgement of current health disparities. "Disparity" implies that someone is not accessing healthcare at all or someone is not getting adequate healthcare access. The trans youth population may be considered at risk for such disparities.

Meanwhile, the lack of a measurable and/or operational definition for healthcare access is a factor in the increasing fragmentation of efforts to develop policies and programs directed toward increasing overall healthcare access, reducing healthcare costs, and enhancing positive healthcare outcomes for all Americans including transgender

persons (McFall & Yoder, 2012b). Gulzar (1999) noted that healthcare access is at the foundation of research concerning health systems, and despite decades of study and the ensuing publications, no effort has been made to synthesize the myriad definitions that exist. It is no wonder, therefore, that a thorough search for relevant literature with “healthcare access” and “access to healthcare” as key words yielded very few articles explicitly defining the concept. Whether both phrases can be construed as synonymous is yet more relevant food for thought worth considering. Whatever the case, this dearth of literature warrants a thorough investigation into the usage and meaning of the phrase “healthcare access.”

The IOM (2011) report defines healthcare as the prevention, diagnosis, treatment, and management of disease and illness through a wide range of services provided by health professionals. Similarly, healthcare means efforts made to maintain or restore health especially by trained and licensed professionals (Merriam-Webster’s online dictionary, n.d.). Meanwhile, Andersen et al. (2007) define access as the actual use of personal health services and everything that facilitates or impedes their use. It is the link between health services systems and the populations they serve. Access means not only visiting a medical care provider but also getting to the right services at the right time to promote improved health outcomes (Andersen et al., 2007). This perspective touches the concept of utilization (actual use of personal health services) often misunderstood for access, and also the ideas of availability, accessibility and compatibility, which are key to access. Penchansky and Thomas (1981) define access as a concept representing the degree of “fit” between the clients and the system and further identify what they consider the dimensions of “access” which are availability, accessibility, accommodation,

affordability, and acceptability. Similarly, Norris and Aiken (2006) also identify what they call defining attributes of access which include availability (geographic proximity and personal convenience), eligibility, amenability, and compatibility, before concluding that access is related to the consumer's actions or intent to use the healthcare system. Gulzar (1999) claims that access may be defined in a variety of ways at different stages of societal development and that there are characteristics related to both the system and the user that have strong implications regarding healthcare access. Such characteristics range from pricing structures, capital and assets, programs, cohort needs (including individual and family attitudes and beliefs), health status (including diagnoses and illness patterns), and cultural needs (Gulzar, 1999). Thus, Gulzar's (1999) view seems to suggest that access can be relative.

Meanwhile, access to healthcare is defined as the capability to attain healthcare that includes available healthcare providers, services, transportation, admittance by facility, ability to meet financial obligation, and insurance benefits (Norris & Aiken, 2006). The idea of availability and eligibility are highlighted here. McIntyre et al. (2009) also identify three dimensions of access which are availability, affordability, and acceptability, through which access can be evaluated directly. They define access to healthcare as the empowerment of an individual to use healthcare and as a multidimensional concept based on the interaction (or degree of fit) between healthcare systems and individuals, households, and communities (McIntyre et al., 2009).

McFall and Yoder (2012b) make the most compelling argument yet on access in their concept analysis of critical access health care in which they identify the domains of availability and demand as the critical attributes of access. They argue that the domain of

availability encompasses spatial and geographic access characteristics which include individual attitudes related to health and health behaviors and system components such as structure location, the process of gaining entry, and navigation pathways experienced by individuals after accessing the system, and these characteristics must be met and maintained to ensure continued access (McFall & Yoder, 2012a). Additionally, availability includes the organization of the health system and available resources in relation to the services and interventions (type, purpose, and interval to access) being delivered and the number of available providers (Aday & Andersen, 1974; Shengelia et al., 2005; McFall & Yoder, 2012b). The services and interventions being provided coupled with available providers must be considered relevant and meet both the perceived and the actual needs of consumers to be considered of value (Shengelia et al., 2005; McFall & Yoder, 2012b). This domain of availability clearly encompasses the attributes of compatibility (available providers must be considered relevant and meet both the perceived and the actual needs of consumers to be considered of value), and, eligibility and accommodation (the process of gaining entry, and navigation pathways experienced by individuals after accessing the system, and these characteristics must be met and maintained to ensure continued access).

The second domain that McFall and Yoder (2012b) identify is demand. They argue that demand is comprised of decisions to seek care, provider selection, qualification (eligibility/insurability), service costs and satisfaction, and further specify that qualification relates to basic economic characteristics of the consumer, as related to the compulsory requirements of the servicing agency (McFall & Yoder, 2012b). They propose that there is a strong link between qualification (eligibility/insurability) and

service costs, especially for consumers who fail to meet compulsory requirements (McFall & Yoder, 2012a).

However, McFall and Yoder (2012a) fail to capture the idea of acceptability which Penchansky and Thomas (1981) capture in their analysis of access. Acceptability as it relates to access is the relationship of clients' attitudes about personal and practice characteristics of providers to the actual characteristics of existing providers, as well as to provider attitudes about acceptable personal characteristics of clients (Penchansky & Thomas, 1981). Penchansky and Thomas (1981) argue that besides the recurrent case in the literature where acceptability has been used in reference to consumer reaction to provider attributes such as sex, age, gender, ethnicity, among others; providers on the other hand, also have attitudes about the preferred attributes of clients or their financing mechanisms. Providers either may be unwilling to serve certain types of clients (e.g. welfare patients, LGBT clients) or, through accommodation, make themselves more or less available (Penchansky & Thomas, 1981). Basically, provider attitude toward clients is decisive in healthcare access especially within the reality of structural violence (e.g. heterosexism, homophobia, racism, ageism, and classism).

The most critical attributes in the definitions of "health" in the literature are the following: well-being as a whole (physically, mentally, socially, and spiritually) for relative optimal functioning and provision of medical services (Kuehn, 2011; IOM, 2011). The attributes for "care" are provision (for what is needed for health), attention, and feelings; worry, anxiety (Miller, Keane, & O'Toole, 2003; Hornby, 2000). When both terms are combined, "health" seems to serve as a qualifier for the kind of care. Nonetheless, we are left with the idea that "healthcare" is the provision of medical

services/and concern for well-being as a whole for relative optimal function.

“Healthcare” in the literature yields the following critical attributes; management (maintenance and restoration of health) and services - by trained and licensed professionals (IOM, 2011; Merriam-Webster online dictionary, n.d.). Provision and management of well-being as a whole for relative optimal function through medical services seems to be an accurate merger of both conclusions. The well-being component retains at least implicitly, the idea of compassion and benevolence which are critical to access especially within the context of health disparities. Most importantly, the notion of acceptability captures the idea of compassion and benevolence which is supposedly inherent in providers of healthcare, while the attributes of provision and management are captured in the attributes of availability and demand.

Based on the available literature, it seems fair to say that there are three critical attributes for healthcare access which include acceptability, demand, and availability (Aday & Andersen, 1981; Andersen et al., 2007; Barnhart, 1995; Cook, 1997; Gulzar, 1999; McFall & Yoder, 2012b; McIntyre et al., 2009; Norris & Aiken, 2006; Penchansky & Thomas, 1981; Shengelia et al., 2005).

Clearly, the concept of healthcare access can be deceptively simple. Having health insurance does not necessarily translate into healthcare access. Also, the availability of healthcare services, does not always translate into utilization. Even more perplexing, the need/demand for and availability of healthcare services does not always mean the consumer receives culturally sensitive healthcare (Harris, 2001).

A working definition of healthcare access assumes that healthcare access exists when the following attributes are present; availability, demand, and acceptability.

However, there is no single measure of healthcare access to date (Wang & Luo, 2005). Therefore, perhaps the most effective measurement of healthcare access would be an evaluation of every case on the individual defining attributes of healthcare access. A qualitative study of healthcare access among trans youth, therefore, will likely permit us gain more insight into empirical referents and attributes of the concept of healthcare access.

The Experiences of Trans Individuals in Healthcare Systems

Stigma and discrimination experienced in healthcare do influence transgender people's healthcare access and utilization. Chapman et al. (2012) performed a descriptive study with the goal of exploring the experiences of lesbian, gay and transgender families accessing healthcare for their children in Australia. The premise was that such families may be fearful about disclosing their sexual orientation or gender identity to health professionals and thus, may not be receiving optimal care for their children. Data for the descriptive qualitative study was collected through semi-structured interviews with lesbian, gay and transgender parents. The negative experiences of the families included encountering homophobia or transphobia and being required to educate health professionals while the positive experience was when both parents were acknowledged as having an equal say in their child's healthcare. The researchers concluded that many health professionals lack the skill or knowledge to meet the needs of lesbian, gay and transgender families and also insist on the need for healthcare services to ensure that all policies and procedures are inclusive of all family constellations and that staff receive relevant and up-to-date sensitivity training and create an environment that is respectful of all family groups. This study touched on important issues faced by LGBT parents within

the healthcare system albeit in Australia and did not focus on trans youth. A similar study in the U.S. that explores the experiences of trans youth would be useful because the American context is not exactly the same as the Australian context.

Furthermore, avoiding medical care because of negative experiences or fear of such experiences is not uncommon among some transgender people (Bauer & Hammond, 2015). The increased risks for suicide, depression and HIV among the transgender population have been associated with stigma and discrimination (Haas et al., 2010; Kattari & Hasche, 2015) while a substantial proportions of LGBT people report unmet need for mental health services (Simeonov, Steele, Anderson, & Ross, 2015). In a study of the residential addiction treatment experiences of transgender individuals who use illicit drugs in a Canadian setting, Lyons et al. (2015) found out that those participants who reported felt and enacted stigma, including violence, left treatment prematurely after isolation and conflicts. In contrast, participants who felt included and respected in treatment settings reported positive treatment experiences. Therefore, fostering respect and inclusivity of gender diverse individuals in residential treatment settings is important (Lyons et al., 2015). The participants also recommended the establishment of transgender and/or LGBTQ specific treatment programs. Such a study needs to be done in the U.S. to understand the experiences of trans individuals in similar healthcare treatment programs.

In a cross-sectional internet-based survey, Hoffman et al. (2009) identified the healthcare preferences of Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth living in the U.S. or Canada. The goal was to determine their preferences regarding healthcare providers, healthcare settings and the health issues that they consider important to discuss with a healthcare provider. The 13-21 year-old

participants (n=733) were asked to review three lists of items pertaining to qualities of healthcare providers, qualities of offices or health centers, and concerns or problems to discuss with a healthcare provider, and then to assign for each item a relative importance. The participants placed as much importance on provider qualities and interpersonal skills as provider knowledge and experience, and placed little importance on a provider's gender and sexual orientation. They indicated the importance of providers addressing not only health risks, but also wellness and health promotion, and to do so within the context of home and family. The authors did a subgroup analyses which underscored the need for greater sensitivity to both cultural and developmental differences among LGBTQ youth. Hoffman et al.'s (2009) work constitutes one of the first studies done with trans youth and the results serve as a foundation for further research about healthcare services and delivery systems for youth, training initiatives for healthcare providers, and the role of utilizing the internet for health research purposes to access and recruit hard-to-reach youth (Hoffman et al., 2009). While understanding the healthcare preferences of these youths is part of the puzzle, exploring the lived experiences of trans youth accessing trans-related healthcare may uncover much more data that will help address healthcare inadequacies in this population. Therefore, a qualitative approach may provide more depth into the unique issues faced by the MtF trans youth population.

Many studies have been done on the risky sexual behaviors, the prevalence and incidence of HIV, and health seeking behaviors among trans populations. Herbst et al. (2008) estimated the HIV prevalence and risk behaviors of trans persons in the U.S. in a systematic review. They found out through meta-analysis that 27.7% (95% confidence interval [CI], 24.8–30.6%) of MtFs tested positive for HIV infection (four studies), while

11.8% (95% CI, 10.5–13.2%) of MtFs self-reported being HIV seropositive (18 studies). Higher HIV infection rates were found among African-American MtFs regardless of assessment method (56.3% test result; 30.8% self-report) (Herbst et al., 2008). De Santis (2009) reviewed the literature on the HIV infection risk factors among MtF trans persons. He found out that factors including needle sharing and substance abuse, high-risk sexual behaviors, commercial sex work, inadequate healthcare access, lack of knowledge regarding HIV transmission, violence, stigma and discrimination, and mental health issues were identified in the literature as risk factors for the acquisition of HIV infection by members of this population (De Santis, 2009). Sevelius et al. (2009) on their part found an association between sex work and hormone use, gender confirming surgeries, and younger age among trans women. The researchers concluded that when developing interventions for trans women, it may be useful to focus on predictors of risk behavior rather than predictors of current HIV status (i.e., race/ethnicity as “risk factor”), because these behaviors are the target of interventions aimed at sexual risk reduction (Sevelius, Reznick, Hart, & Schwarcz, 2009). Meanwhile, Garofola et al. (2006) described the real life challenges and HIV-risk behaviors of MtF trans youth from communities of color. Among the 52 participants aged 16-25 years, sex in exchange for resources (59%), forced sexual activity (52%), difficulty finding a job (63%), and difficulty accessing healthcare (41%), among others, were the challenges faced by this population. Within the past year, 98% had sex with men, 49% had unprotected receptive anal intercourse, and 53% had sex under the influence of drugs or alcohol. Twenty-nine percent of participants had used injection liquid silicone in their lifetime. The authors concluded that the findings suggest that MtF trans youth of color have many unmet needs and are at extreme risk of acquiring

HIV and recommend further research to better understand this adolescent subgroup and to develop targeted broad-based interventions that reduce risky behaviors (Garofalo et al., 2006).

Harawa & Bingham (2009) assessed the level of exposure to active and passive HIV prevention services and identified which subgroups were underserved in a Los Angeles population of female sex workers (FSW) and MtF persons. Both groups reported more passive than active prevention exposure, with overall participation less common for FSWs than for MtF. Although some differences were observed between groups, predictors of lower HIV prevention utilization identified in both study populations included African American (versus Hispanic) race/ethnicity, higher household incomes, cohabitation/ marriage, and not seeking recent health care (Harawa & Bingham, 2009).

From the literature, it appears that stigma, transphobia, discrimination, and a lack of knowledge and training about trans healthcare needs all make for a poor healthcare experience for trans individuals. The consequences range from sheer avoidance of treatment to depression and suicide. In addition, it seems that there has been an overemphasis on HIV and its associated risk factors and treatment among trans populations. While HIV is certainly a relevant problem in the trans population, such an over-emphasis has the potential to further stigmatize this population. In addition, many studies reported in the literature were conducted in Canada, which provides healthcare for all citizens unlike in the U.S. Few studies found in the literature on trans youth have been conducted in the U.S. Regardless of the location, however, trans youth seem to be at higher risk for poor healthcare outcomes. There is, therefore, an urgent need to explore

the healthcare experience of trans youth in the U.S. and to identify better approaches to addressing their perceived needs.

Barriers and Facilitators to Healthcare among Transgender Individuals in the Literature

Several barriers to healthcare access among the transgender population exist. These barriers seem to be more structural in nature. The major barriers to provision of transgender-related care are lack of the following in healthcare professionals: training, exposure to transgender patients, available qualified mental health providers, stigma and discrimination, and insurance reimbursement (Obedin-Maliver et al., 2011; Vance, Halpern-Felsher, & Rosenthal, 2015). Poteat, German, & Kerrigan (2013) posit that because of the social and institutional stigma against transgender people, their care is excluded from medical training. They argue that providers approach medical encounters with transgender patients with ambivalence and uncertainty to say the least and transgender people anticipate that providers will not know how to meet their needs (Poteat et al., 2013). They further argue that uncertainty and ambivalence in the medical encounter upsets the normal balance of power in provider-patient relationships while suggesting that in the face of provider uncertainty, interpersonal stigma functions to reinforce medical power and authority. The researchers highlight the importance of acknowledging the role of power especially within functional theories of stigma, and to understand how stigmatizing attitudes function to maintain systems of inequality that contribute to health disparities (Poteat et al., 2013).

This uncertainty and lack of training among providers was also examined by Snelgrove et al. (2012) in a qualitative analysis of Canadian physician-side barriers to

providing healthcare for transgender patients. The study revealed healthcare barriers that grouped into five themes: accessing resources, medical knowledge deficits, ethics of transition-related medical care, diagnosing vs. pathologizing trans patients, and health system determinants (Snelgrove et al., 2012). This study showed that physicians perceived barriers to the care of trans patients, and that these barriers were multifactorial. First of all, access barriers impeded physicians when referring patients to specialists or searching for reliable treatment information. In addition, clinical management of trans patients was complicated by a lack of knowledge, and by ethical considerations regarding treatments which could be unfamiliar or challenging to physicians (Snelgrove et al., 2012). The participants revealed that the disciplinary division of responsibilities within medicine further complicated care; few practitioners identified trans healthcare as an interest area, and there was a tendency to overemphasize trans status in mental health evaluations. The authors warned that a failure to recognize and accommodate trans patients within sex-segregated healthcare systems will inevitably lead to deficient health policy. The study results suggested that potential solutions to trans healthcare barriers were at the informational level (with increased awareness of clinical guidelines and by including trans health issues in medical education) and at the institutional level, with support for both trans-focused and trans-friendly primary care models. A study of this dimension and depth within the U.S. healthcare context is necessary for a better understanding of barriers to care among trans youth.

In an ethnographic study of LGBT individuals in a rural area in New Mexico, Willging et al. (2006) sought to examine the social dynamics of communities and clinic settings that impede the delivery of culturally relevant services of LGBT people living in

rural areas. Twenty providers were interviewed to document their perceptions of LGBT mental health care. Most of the rural providers claimed that there was no difference between working with LGBT clients and non-LGBT clients (Willging et al., 2006). This view is quite problematic for its surface “politically correct” approach to populations falling outside the heterosexist norm while ignoring essential differences within these diverse populations. In addition, many LGBT clients had been denied services, discouraged from mentioning sexuality and gender issues by providers, and secluded within residential treatment settings. The authors conclude that the challenges of ensuring access to quality care for this population are magnified by provider discourses of “therapeutic neutrality” and lack of education about LGBT mental health issues, and homophobia influenced services for rural LGBT persons (Willging et al., 2006).

Sanchez et al. (2009) investigated health care utilization, barriers to care, and hormone use among MtF trans persons (n=101) residing in New York City to determine whether current care is in accord with the World Professional Association for Transgender Health and the goals of Healthy People 2010. Most participants reported having health insurance (77%; n = 78) and seeing a general practitioner in the past year (81%; n = 82). Meanwhile, over 25% of participants perceived the cost of medical care, access to specialists, and a paucity of transgender-friendly and transgender-knowledgeable providers as barriers to care. Also, being under a physician’s care was associated with high-risk behavior reduction, including smoking cessation ($p = .004$) and obtaining needles from a licensed physician ($P = .002$). MtF trans persons under a physician’s care were more likely to obtain hormone therapies from a licensed physician ($P < .001$). The authors conclude that utilization of healthcare providers by MtF trans

persons is associated with their reduction of some high-risk behaviors, but it does not result in adherence to standard of care recommendations for trans individuals (Sanchez et al., 2009). It should be noted that this study was not done with trans youth and was done before the advent of the PPACA. How the ACA may or may not affect these dynamics will be an interesting focus of future research.

Meanwhile, a 2011 Veterans Health Administration (VA) directive mandated medically necessary care for trans veterans (Blosnich et al., 2013; Kauth et al., 2014). Staff members were informed by the internal education of the directive which would promote greater access to care. Kauth et al. (2014) from 2006 through 2013, identified 2,662 unique individuals with diagnoses related to transgender status in the VA medical records, with 40% of new cases in the 2 years following the directive. The authors found out that a bottom-up push for services by veterans and top-down education likely worked synergistically to speed implementation of the new policy and increase access to care (Kauth et al., 2014). The study concluded that patient satisfaction can be enhanced through culturally competent health care, quality assurance, and patient feedback. While these authors found these approaches effective in ensuring and facilitating access to healthcare among veterans, the application of these approaches in the non-veteran trans youth population remains unstudied.

Stroumsa (2014) reviewed the current status of transgender people's access to healthcare in the U.S. and analyzed federal policies regarding healthcare services for trans people and the limitations thereof, with the coming into law of the PPACA. She suggested a preliminary outline to enhance healthcare services and recommended the formulation of explicit federal policies regarding the provision of healthcare services to

trans people in accordance with recently issued medical care guidelines, allocation of research funding, education of healthcare workers, and implementation of existing nondiscrimination policies (Stroumsa, 2014). Perhaps most importantly, this researcher noted that current policies denying medical coverage for sex reassignment surgery contradict standards of medical care and insists on its amendment (Stroumsa, 2014). An overwhelming majority of medical authorities recognize transition-related care as an effective and medically necessary treatment for gender dysphoria, yet many providers and insurance companies refuse to treat or recognize the necessity of transition-related care (Kurzweil, 2014). Limited financial resources and a lack of access to transition-related services, may contribute to non-prescribed hormone use and self-performed surgeries (orchiectomy or mastectomy) (Rotondi et al., 2013; Sevelius et al., 2014). Gage (2015) reiterates that despite trans individuals' heightened reliance on medical care, this community has historically been excluded from medical insurance. Meanwhile, while the ACA altered this landscape by allowing many individuals previously excluded from health insurance - due to pre-existing conditions or prohibitively high rates - to access affordable plans, many access barriers are still unresolved (Gage, 2015). While expansion of state-administered Medicaid paired with PPACA's individual mandate means that many transgender individuals will have medical insurance for the first time, Gage (2015) cautions that this gain is not a total victory because improved access to health insurance for trans individuals does not necessarily mean improved access to medically necessary, gender-confirming health care. These researchers suggest shortfalls pertaining to the PPACA. How trans youth are affected by the law's provisions might be interesting to study.

Elsewhere, Chakrapani, Newman, Shunmugam, & Dubrow (2011), examined barriers to free antiretroviral treatment access among men who have sex with men (MSM) and MtF persons in Chennai, India. They found out that strong motivations to keep one's HIV-positive status and same-sex attraction secret were interconnected with sexual prejudice against MSM and trans persons, and HIV stigma was prevalent in families, the healthcare system, and the larger society. HIV stigma was present within MSM and MtF communities as well. Consequences of disclosure, including rejection by family, eviction from home, social isolation, loss of subsistence income, and maltreatment within the healthcare system, presented powerful disincentives to accessing ART (Chakrapani et al., 2011). Socías et al. (2014), explored individual, social-structural and environmental factors associated with healthcare avoidance among trans women in Argentina. Despite Argentina's universal health care system and laws designed to promote healthcare access among trans women, the researchers found out that avoiding healthcare was associated with stigma and discrimination in healthcare settings, as well as police violence experiences (Socías et al., 2014).

Conclusion

It appears that as awareness of trans men and women grows among researchers, clinicians, policymakers, and educators, there is also a corresponding need to create a more inclusive healthcare setting. Lombardi (2010) suggests that greater sensitivity and relevant information and services are required in dealing with the transgender population. Lombardi (2010) goes further to advocate that these individuals need better access to healthcare resources, need their identities to be recognized as authentic, and they need education and prevention material appropriate to their experience. Perhaps more than

anything else, a need exists for activities designed to enhance understanding of trans health issues and to spur innovation (Lombardi, 2010). Towards this end, therefore, a comprehensive exploration of the lived experience of MtF trans youth accessing trans-related healthcare access is relevant.

A handful of studies on transgender persons have been conducted with important merits and deficits. Generally, many of the studies published have sought to explore some of the issues that the transgender population face including HIV prevalence and risky sex behaviors, HIV prevention utilization, suicide and its risk factors, substance use and abuse, victimization, and provider tendency to overemphasize trans status in mental health evaluations. With an overemphasis on HIV by researchers and a tendency to pathologize or overemphasize trans status in mental health evaluations by providers, this community seems at risk for further stigmatization. Moreover, very few studies focus on trans youth and their healthcare experiences. When studies do focus on trans youth, they do not always seem to fully explore their lived experience and perceptions of trans-related healthcare access. This is obviously a significant gap worth exploring to better address the healthcare needs of this population.

Philosophical underpinnings

The phenomenon of living as a transgender individual is in fact relatively new and not so much is known about the transgender population in terms of access to trans-related healthcare services. The phenomenological approach which fulcrums on Husserl's descriptive phenomenology basically explores the meaning of being a person (transgender) in the world, seemed most apt for this study. The aim of descriptive phenomenology is to explore in detail how participants are making sense of their personal

and social world, and the main currency for a phenomenological study is the meanings particular experiences, events, states hold for participants (Smith, Flowers, & Osborn, 1997). In fact, meaning is found in the transaction between an individual and a situation so that the individual both constitutes and is constituted by the situation (Heidegger, 2013). The phenomenological approach thus permitted the exploration of the ascribed meaning associated to accessing trans-related health services among trans youth as they experience and perceive it. Holloway & Wheeler (2013) describe phenomenological research as focusing on the lifeworld, lived experiences that are described by the participants who reflect on them. Interpretation of the experience from the individual's unique perception of an event is critical (Munhall, 1994). According to Munhall (1994), what is important from the worldview, is not what is happening but what is perceived as happening. Phenomenology should help us gain insight and extract common themes – essences or meanings – which humans have in common and that go beyond individual cases (Holloway & Wheeler, 2013). The goal of this study was to generate new, contemporary and meaningful knowledge that would help to (co)construct a holistic picture of the transgender healthcare experience.

Chapter Three

The Means of Inquiry

This chapter presents an overview of the phenomenological method and rationale for its selection to guide the study. A historical overview of phenomenology is discussed. Data collection, data management, and analysis are equally discussed.

Method of Inquiry: General

This was a descriptive qualitative study of trans youths' lived experiences accessing trans-related healthcare within the context of U.S. healthcare. The study was grounded philosophically in phenomenology as developed by Husserl. The holistic perspective which is central to professional nursing, coupled with the study of lived experiences, provides the foundation for phenomenological research (Holloway & Wheeler, 2013; Speziale, Streubert, & Carpenter, 2011). Today's nursing practice emphasizes an individualized approach to patient care that shares many of its underlying beliefs and values with the phenomenological philosophical thought (Jasper, 1994). Phenomenology provides a framework for a method of research and as a research method, and aims to describe, understand and interpret the meanings of experiences of human life (Bloor & Wood, 2006). Phenomenology focuses on revealing meaning rather than on arguing a major point or developing abstract theory (Flood, 2010). The researcher's aim is to understand the cognitive subjective perspective of the person who has the experience and the impact that perspective has on the lived experience (Flood, 2010). A brief over of the phenomenological movement is necessary.

Historical Overview of Phenomenology

Franz Brentano is identified as the forerunner of the phenomenological movement

(Spiegelberg, 1965). Edmond Husserl (1859-1938), the German philosopher is however acknowledged as the trailblazer of the phenomenological movement (Koch, 1995).

Rooted in the early works of Plato, Socrates, and Aristotle who struggled to understand phenomena, phenomenology flourished in the 20th century under Husserl (Fochtman, 2008). Husserl made progress in defining and making the case for phenomenology as a rigorous and unbiased approach to inquiry that sought essential understanding of human consciousness and experience (Munhall, 1994; Spiegelberg, 1965). The German philosopher was part of the second of three phases of this branch of philosophy; preparatory, German, and French (Cohen, 1987; Munhall, 1994). Spiegelberg (1965) described phenomenology as a movement as opposed to a stationary philosophy. A brief overview of the three phases is necessary.

The first phase of the phenomenological movement was dominated by the work of Frank Brentano (1838-1917) during the last quarter of the 19th century. In fact, he is the very first person to write about phenomenology as a method of inquiry and is credited with two major contributions. His discussion of the value of “inner perception” which is basically an awareness of our own psychic phenomena as opposed to unreliable introspection was the first (Munhall, 1994). The concept of “intentionality” implying the inseparable connectedness of the human being to the world was first discussed by Brentano and this would constitute his second major contribution (Munhall, 1994; van Manen, 2015). Cohen (1987) points out that intentionality would become a concept basic to all later phenomenological analysis. Carl Strumpf (1848-1936) furthered the movement by insisting that the method could be studied with the rigor of experimental and scientific techniques (Spiegelberg, 1965). According to Spiegelberg (1965), Strumpf

never believed in dissecting the world at the price of destroying the connections. This perspective is evident in many of the present-day phenomenological movements (Munhall, 1994, 2012).

Husserl and Martin Heidegger (1889-1976) were the dominant figures of the German phase of the phenomenological movement. Husserl is considered the most eminent figure of phenomenology (Cohen, 1987). Disenchanted with the positivism-empiricism position that emphasized facts only as the final truth, he espoused the view that phenomenology be used as a creative attempt to apprehend meaning through the study of humans (Munhall, 1994). Munhall (1994) points out that Husserl attempted to restore the “reality” of humans in their “life worlds”, to capture the “meaning” of this, and to revive philosophy with new humanism. Subjectivity thus began to dominate this philosophy and was the source of all objectivities (Cohen, 1987; Munhall, 2012). This view is in fact one that allows for individuals’ voices to be heard and is at the core of individualized care in nursing science.

Meanwhile, Husserl placed emphasis on the concept of “essences” which is one of his major contributions to the development of phenomenology (Cohen, 1987). “Essence” derives from the Greek word “ousia” which means the true being of a thing, the inner essential nature of a thing. van Manen (1990) adds that essence is that which makes something what it is (without which it would not be what it is); it is that which makes a thing what it is rather than its being or becoming something else.

Cohen (1987) noted two major concepts within Husserl’s work. The two concepts are “intersubjectivity” and “life world” (Lebenswelt) meaning the world of lived experience. Intersubjectivity is what the human science researcher needs - the other (the

participant) - to develop, in order for the dialogic relation with the phenomenon to occur, thus validating the phenomenon to occur, thus validating the phenomenon as described (van Manen, 2015). Munhall (1994) notes that in this respect, researchers who share the common world, are required to “bracket” their identification with the participants’ experience if they are to be able to study the phenomenon; setting aside pre-judgement. In phenomenological studies to this day, this methodological requirement is an essential technique if the results are to be considered reliable (Oiler, 1982). The post-modern epistemological perspective is inherent in the idea of intersubjectivity which recognizes the complexity of the human experience which is experienced intersubjectively and has meaning (Bevan, 2014).

The second concept is the life-world in the phenomenological movement credited to Husserl (Cohen, 1987). It is the world of lived every day experience. Munhall (1994) points out that this life-world is our everyday experiences which we often fail to notice because it has become so commonplace to us. That which surrounds us can really be seen with renewed awareness through phenomenological studies (Cohen, 1987).

Heidegger was the second influential philosopher in the second phase of the phenomenological movement. He is well known for his concept of “Being”. “Being” is always the Being of an entity and so to inquire about the being of something is to inquire into the nature of meaning of that phenomenon under study (van Manen, 2015). “Being” according to van Manen (1990), is a fundamental term of the human science research process itself. The individual participates in cultural, social, and historical contexts of the world and as such is said to “be-in-the-world” (Munhall, 1988).

The German phase gave birth to the two major approaches to phenomenology;

descriptive phenomenology (Husserl) and interpretive phenomenology also called hermeneutics (Heidegger). The German phase ended with the advent of World War II, and led to the French phase.

Gabriel Marcel (1889-1973), Jean-Paul Sartre (1905-1980), and Maurice Merleau-Ponty (1908-1961) are recognized as key members of the French phase of the phenomenological movement. Marcel saw phenomenology as a useful introduction to the analysis of “Being” while Sartre’s goal was to understand because “to understand is to change, to go beyond oneself” (Cohen, 1987; Munhall, 1994). Sartre expanded phenomenology as an alternate research method and as a method of inquiry (Spiegelberg, 1965). Merleau-Ponty’s version of phenomenology related to experienced time, space, body, and human relation as we live them (Munhall, 1994). Accordingly, the effort to describe human experience as it is lived, is what phenomenology is about.

The current study was philosophically grounded in Husserl’s approach to phenomenology. Husserlian phenomenology focused on description which was further developed by the Duquesne school of researchers made up of Van Kaam, Colaizzi, and Giorgi. Mapp (2008) pointed out that Paul Colaizzi’s approach to data analysis was the most user-friendly and could be applied by a novice or experienced researcher to provide a clear description of the phenomenon under study. His method differs from both Giorgi and Van Kaam in that final validation of the study is provided by the participants who are given the description of the experience to verify (Mapp, 2008). Colaizzi believed that the phenomenologist’s goal was to accurately describe phenomenon as seen through the eyes of the study participants (Phillips-Pula, Strunk, & Pickler, 2011). The Husserlian approach is favored by this researcher because it does not have the constraints of the

Heideggerian approach whereby the researcher is required to have detailed firsthand knowledge on the subject matter in order to provide an interpretation (Mapp, 2008).

According to Mapp (2008), Husserlian phenomenology can provide a greater degree of flexibility since the researcher is not required to have in-depth knowledge of the data under investigation but it is still able to provide a very vivid descriptive account of the lived experience from the perspectives of those who have experienced them. This vivid description account is central to data analysis which is emphasized in Colaizzi's approach. In fact, the purpose of data analysis in phenomenology is to preserve the uniqueness of each lived experience of the phenomenon while permitting an understanding of the meaning of the phenomenon itself (Banonis, 1989; Jasper, 1994). In conclusion, phenomenology seeks to describe a human experience as it is lived and expressed by those experiencing a phenomenon for a better understanding of the individual human experience.

Method of Inquiry: Applied

The phenomenon of living as a transgender and accessing trans-related healthcare is currently understudied with no published documentation regarding it. Thus, phenomenology was an appropriate method for an initial investigation of a relatively unexplored phenomenon. By capturing the lived experiences of transgender youth, an initial knowledge base was created to build upon in future research. The following was the specific aim of this study:

1. Explore the perceived meaning of accessing transgender-related healthcare

Setting and Sample

The study site was Los Angeles (L.A.) County, California and the sample was

Male-to-Female (MtF) trans youth ages 21– 24. The choice of L.A. was appropriate as MtF young people now constitute a significant segment of the population in L.A. County. A previous study on trans youth in L.A. conducted by Wilson et al. (2009) examined HIV risk behaviors and experiences in this population. The current study built upon this work by expanding the research focus to the lived experiences of MtF young people accessing trans-related healthcare.

The choice of MtF trans youth as the focus of this research was appropriate for several reasons. First of all, they are an extremely vulnerable population. According to Melendez & Pinto (2007) MtF trans individuals appear to turn to men to feel loved and affirmed as women. Their main HIV risk stems from their willingness to engage with sexual partners who provide a sense of love and acceptance but who may also request unsafe sexual behaviors (Melendez & Pinto, 2007). The social expression of trans identity is the strongest and most consistent predictor of HIV/STIs (Nuttbrock et al., 2009). MtF trans youth, like other young people, are undergoing a crisis of identity. However, unlike their heterosexual counterparts, they are often rejected by family and friends, and are thus in danger of being homeless, jobless, and at risk of contracting HIV. Thus, MtF trans young people are a vulnerable population with many health risks who currently remain understudied.

Inclusion and Exclusion Criteria

MtF trans youth ages 21-24 living in Los Angeles County and fluent in the English language were recruited for this study. Non-English language speakers were excluded from the study due to lack of financial resources to pay for translation services.

Data Collection

Participants were recruited using purposeful and theoretical sampling after initial study advertisement using fliers on trans websites and nightclubs in Los Angeles.

Populations that are traditionally underserved might be more difficult to reach because of a variety of personal or socio-demographic characteristics. Groups with documented difficulty for research recruitment include stigmatized persons, people living with HIV/AIDS, and members of the gay, lesbian, or transgender communities (Sadler, Lee, Lim, & Fullerton, 2010). According to Holloway & Wheeler (2013), theoretical sampling develops as the study proceeds, and it cannot be planned beforehand. This approach was apt for this new phenomenon given the unknowns and its unpredictability. Using both approaches seemed apt even though Sandelowski (1995) maintains that all sampling in qualitative research is purposeful and that theoretical sampling is a variation of purposeful (also called purposive) sample.

Data was collected using in depth one on one face-to-face semi-structured digitally recorded interviews. According to Wojnar and Swanson (2007) an important tenet of the Husserlian approach to science is the belief that the meaning of lived experiences may be unraveled only through one to one transactions between the researcher and the objects of research. Through interviewing, researchers presumably gain full access to the inner feelings and thoughts, uncovering the private self of the participants (Atkinson & Silverman, 1997). Holloway & Wheeler (2013) state that if researchers apply high standards and rigor to the research and search for contrary occurrences in the analysis of the interview data, their studies will represent to some extent the reality of most of the participants' perceptions and a description of the

phenomenon under study. This study sought to tap into the inner feelings and thoughts of trans youth and to get an insight into their lived experiences accessing trans-related healthcare. Through interviews, the researcher explored in detail the experiences, motives, and opinions of MtF trans youth and learned to see the world from their perspectives (Rubin & Rubin, 2011).

Each interview ran for no more than one hour and consisted of one major open ended interview question designed to meet the specific aim of the study. The typical interview question was “Please tell me what it means for you to get trans-related healthcare services?” Probes were used to elicit more detailed information or for clarification. Responses were elicited to the point of saturation.

Data Analysis

Following transcription, digitally recorded qualitative interview data was coded and analyzed for themes. The descriptive phenomenological strategy developed by Colaizzi (1978) consisting of 7 steps was used to integrate significant statements into principal themes. The following is an outline of the seven steps:

1. Every single transcript was read several times to gain a sense of the whole content. Any thoughts, findings, and ideas that arose due to the researcher’s previous work with incarcerated transgender individuals were added to the bracketing diary during this stage. This was useful in focusing on the phenomenon under study: exploring lived experience accessing trans-related healthcare.
2. Significant statements and phrases pertaining to the lived experience of trans youth accessing trans-related healthcare were extracted from each

transcript. These statements were written on separate sheets and coded based on their “transcript, page, and line numbers”. After these significant statements were extracted from the transcripts, the researcher consulted with a transgender research expert who also had access to the transcripts. Consensus was reached on the significant statements and phrases. One hundred and thirteen significant statements were extracted from the nine transcripts.

3. Meanings were formulated from the significant statements. Every single underlying meaning was coded in a category to reflect an exhaustive description. Similarly, the researcher and transgender research expert compared formulated meanings with the original meanings while maintaining the consistency of descriptions. Minimal differences were found between the two researchers. One hundred and thirteen formulated meanings were derived from 113 significant statements. A research expert checked for correctness and consistency of the significant statements and formulated meanings.
4. With consensus reached on all formulated meanings, the process of grouping all formulated meanings into categories reflecting a unique structure of clusters of themes was initiated. Each cluster of themes was coded to include all formulated meanings related to that group of meanings, after which groups of clusters of themes reflecting particular issues were incorporated together to form a distinctive construct of themes. The researcher later compared his clusters of themes with those

of the transgender research expert for accuracy of the overall thematic map. Ten theme clusters emerged which were grouped later into three emergent themes.

5. At this stage of the analysis, all emergent themes were defined into an exhaustive description. After all study themes were merged, the whole structure of the phenomenon “lived experience of trans youth accessing trans-related healthcare” was extracted. The findings were reviewed by a transgender research expert (who is also a trans woman) and research participants (stage 6) for richness and completeness to provide sufficient description and to confirm that the exhaustive description reflected the lived experience of trans youth accessing trans-related healthcare in Los Angeles. Finally, the exhaustive description was validated by the dissertation chairperson and a committee member.
6. Upon returning to participants to validate the finding, no exhaustive meanings were sought at this stage. In this step a reduction of findings was done in which redundant, misused or overestimated descriptions were eliminated from the overall structure. Some amendments were applied to generate clear relationships between clusters of themes and their extracted themes, which entailed eliminating some ambiguous structures that weakened the whole description. The challenge here was to stay in touch with these hard to find trans youth participants. However, significant attempts were made to reschedule meetings with the participants with some success.

7. Finally, there was incorporation of some changes based on the informants' feedback to present a theoretical model that comprehensively reflected the universal features of living as a MtF trans youth and accessing trans-related healthcare within the context of U.S healthcare (Colaizzi, 1978; Shosha, 2012; Wojnar & Swanson, 2007).

Figure 1: Illustration of the process of phenomenological data analysis created by Colaizzi (1978).(Shosha, 2012).

Ethical Consideration

Study oversight was provided by the Institutional Review Board (IRB) of the University of San Diego. Every participant was read and given a copy of the consent form and encouraged to ask questions. The consent form highlighted their right to refuse to participate and their right to withdraw from the study at any time. Each participant received a \$25 gift card as incentive, regardless of whether they completed the entire interview or not.

Chapter Four

Findings of the Inquiry

The following chapter details the findings of the inquiry. Findings include a description of the participants. Three themes emerged during the analysis to reveal the whole structure of the phenomenon “lived experience of trans youth accessing trans-related healthcare” that is intimately linked to the attributes of healthcare access which include availability, demand, and acceptability.

Participants

There were 9 participants in this study who were aged 21-24 years (average age of 23 years) who met eligibility criteria. Four of the participants were African-Americans, two were Caucasians, two were Hispanics, and one was Asian. Eight of the nine participants were at stage two of their transition (meaning that they were taking or had taken hormones). One of the participants was at stage 1 of transition (dressing as female, wearing wigs, make-up, etc) and did not plan to take hormones (Stage 2 of transition). Seven out of the nine participants were unsure or did not want to undergo sex reassignment surgery (SRS) (Stage 3 of transition). The other two were looking forward to and getting ready for SRS. Table 1 highlights demographic information of the participants.

Five of the participants were involved or had been involved in sex work. Two of the five participants involved in sex work said they were HIV (Human Immunodeficiency Virus) positive. Four of the trans girls had experienced homelessness or were homeless at the time of the interviews. Two of the nine participants had been to prison at least once,

and two of the nine trans girls had been taking illegal drugs or were taking illegal drugs at the time of the interviews.

Table 1

Participants' Demographic Information

Participant	Age (years)	Race/ Ethnicity	Gender identity	Stage 1 of transition	Stage 2 of transition	Stage 3 of transition	Opinion on Sex Reassignment Surgery (SRS)
1	24	African American	Trans woman	Yes	Yes	No	Wants SRS
2	23	Hispanic	Trans woman	Yes	Yes	No	Does not want SRS
3	21	African American	Trans woman	Yes	Yes	No	Does not want SRS
4	24	Asian	Trans woman	Yes	Yes	No	Does not want SRS
5	21	Caucasian	Trans woman	Yes	Yes	No	Wants SRS
6	22	African American	Trans woman	Yes	No	No	Does not want SRS
7	24	Caucasian	Trans woman	Yes	Yes	No	Does not want SRS
8	24	African American	Trans woman	Yes	Yes	No	Does not want SRS
9	23	Hispanic	Trans woman	Yes	Yes	No	Does not want SRS

Appendix A provides the complete list of the significant statements extracted.

Appendix B shows how significant statements were converted into formulated meanings.

Ten theme clusters emerged that were grouped later into three emergent themes

(transitioning, self-fulfillment, and transgender community solidarity). Appendix C

shows the process of constructing the various themes through integration of various

clusters of themes. The final thematic map is illustrated in Appendix D. Next is the exhaustive description of the lived experience of the trans youth in Los Angeles accessing trans-related healthcare. It must be recalled that the aim of the study was to explore the perceived meaning of accessing trans-related healthcare.

Transitioning

The theme of transitioning is the first major theme that was generated from the data and is at the heart of the lived experience of trans-youth in Los Angeles accessing healthcare. This theme is intimately linked to at least two of the attributes of healthcare access. It must be recalled that the literature had espoused a working definition of healthcare access that assumes that healthcare access exists when the following attributes are present; availability, demand, and acceptability. These attributes will be discussed as they relate to the theme of transitioning. It is however, important to start off with a detailed description of the lived experience of trans-youth transitioning.

The process of transitioning was described by the participants in great detail. For all the participants, prior to transitioning, they had felt they were different from an early age and did not recognize themselves in the sex they were born into. Many of the participants reported not being able to relate to boys when they were growing up and felt their bodies were feminine trapped in male bodies. This awareness of their perceived feminine core left most of the participants unhappy as they lived with a different gender. The uncomfortable feeling living as a boy was so powerful that it kept some participants silenced but it was also enough motivation for all the participants to transition. In fact, most of them started transitioning in their teenage years. Some had come out at an early age and the rest came out in their teenage years which coincided with their transition.

Coming out is the process of accepting and telling others about one's heretofore hidden gender identity (Vargo, 1998). Coming out therefore gave all of the participants a chance to start living their life in their perceived gender and this meant accessing trans-related healthcare (use of hormones) for transitioning.

The motivation and dedication to transition was so strong that many of the participants left their families traveling from faraway states (Arizona, Colorado, Florida, Ohio, and New York) to come to Southern California, and others traveled from other cities in California (San Jose and San Bernardino) to live in Los Angeles and access trans-related healthcare that allowed them to transition. The dedication for some meant risking it all and leaving their families behind in search of an accepting and trans-related healthcare resourceful environment.

Eight out of the nine participants were very certain about their decision to transition for life whereas one of the nine participants indicated that transitioning was more of an experiment to her which would allow her see if she really wanted it. For most of the participants, however, transitioning, facilitated by accessing trans-related healthcare, was not a choice:

...For me it's not a choice. I don't know, I can't – I don't know, like I can't go back to being like a man and ignore what I ever want to be. I couldn't emotionally, physical or like, I don't know. I just think, I am a woman, like I act like, I don't know, I just feel that. [Participant #6]

The choice of moving to California, and specifically Los Angeles, by most of the participants was because the participants perceived Southern California to be trans-friendly with many trans-healthcare resources to help with transitioning. In order for the

participants to transition, they needed access to the transition resources. Six of the nine participants said they qualified for Medi-Cal which paid for their hormones. Medi-Cal is an extension of California's Medicaid program. Meanwhile, some participants were directed by other trans girls who had transitioned on how to get hormones. Eight of the participants could name the clinic or hospital in Southern California that they went to for hormone therapy and for peri-transitioning counseling. Two participants however, said they started hormone therapy while in prison where they were prescribed and given hormones by a Physician. The LGBT Center was also repeatedly mentioned as a resourceful place for getting information on where to get trans-related healthcare.

According to the participants, transitioning was a three-step process and they vividly described it. Stage one entailed dressing as a woman, maybe wearing wigs or putting on hair extensions, wearing make-up, going by a female name, and did not entail hormone therapy. This step allowed the participants to get comfortable being women. Stage two was the hormone phase (pills or shots) characterized by breast enhancement, voice softening, and face softening. Sex Reassignment Surgery and legal name change characterized the third and last stage of transitioning. The participants were mostly in the second stage of transitioning and reported knowing people who did not follow the steps chronologically. They reported that they knew people who got surgery before starting hormone therapy to speed the process.

Many of the participants seemed to agree that they started transitioning by dressing like women, wearing wigs and make-up (stage one), before ever taking hormones. Many more also highlighted the fact that some counseling was done before they could start hormone therapy in accordance with current standards of care for trans

individuals. Some of the hormones received by the participants included Estradiol, Progesterone, and Premarin (conjugated estrogen tablet), and also spironolactone (testosterone blocking drug). Many of the participants reported going back for blood work and check-up every 3 months after starting hormone therapy which for many had been going on for at least 3 months and at most 2 years. This also met the standards of care for trans individuals. Transitioning especially stages 2 and 3 clearly entailed accessing trans-related healthcare.

Transitioning also caused much anxiety among some of the participants even though the determination to live as women seemed stronger than the anxiety associated with accessing and using hormones:

And then, you know, I really wanted to know, will I look pretty or are things going to like happen the way I want them to happen and I was really scared. In the first six months I really was in that questioning phase, like, is this right? Am I going to do this? Am I strong enough? Can I handle what everyone's going to say? Can I handle dealing with it for however long? I may get hormones for years and years and years, but I gotta make sure I could handle it before I really went all out. And I finally realized like, yeah, there's nothing that can stop me from being who I want to be. Because I thought for hours and days and months about if it was what I truly, truly wanted to do. [Participant #7]

For most of the participants, the first 6 months of transitioning were the hardest characterized by moments of doubts related to what most of the participants perceived to be an irreversible process. The doubts were compounded by the homelessness in which

some of the participants found themselves at the time they started transitioning. Despite these anxieties and doubts, however, some trans girls would take the risk of using illegally bought hormones from the streets. Self-administering hormones using needles is a dangerous and risky practice. One participant asserted that some trans girls took illegally prescribed hormones via injection for quicker results. None of the participants however, reported ever taking illegally prescribed hormones. Access to hormones was therefore fundamental in transitioning. One participant said: *The hormones have been working, the healthcare, every resource that I took they worked out a lot good for me and I'm just blessed...*

Enhanced feminine features were reported by all the participants who used hormones. One of the participants said *"Since I've been taking them [hormones], I've been – it makes me feel more womanly, more, you know."* Access to hormones and its intimate link to transitioning was echoed by most of the participants. Another participant added that: *"You could see the glow and people, when people take the hormones you can tell the difference..."* For one other participant who used hormones, however, it was really more about her inner self as a woman than it was about the hormones. For her, it was the inside that mattered; despite that she was using hormones for enhancement, and was happy with it.

Despite the desired effects of hormone therapy, most of the participants reported side effects associated with the therapy that made for a challenging experience. Most participants reported mood swings, depression, and some said they could not have a penile erection after using estrogen. Some of the participants also expressed regrets regarding perceived inability to procreate following use of hormones, wishing they had

saved their sperm for later use. One participant was however consoled by the option of adopting kids.

The last phase of transitioning is SRS critical phase in the transitioning process, counseling with a psychiatrist was not unusual before SRS according to the participants. This is followed by legal name change according to three of the participants. All but one participant wanted to have the surgery while the rest of them were unsure or totally against it. The perceived ability to get the men she wanted, was an additional motivating factor for one of the trans girls who wanted SRS. Uncertainty about SRS typically characterized the participants with most of them expressing reservations and the need to get more information (through counseling especially) before making the decision. Those who did not want SRS said they felt SRS was going against or playing with God. One other participant felt it was unnecessary to do SRS because no matter what, she would never become a 100% complete biological female.

The first theme, Transitioning, is fundamentally characterized by hormone use, surgery and counseling services that entailed accessing trans-related healthcare services. Hormone use led to breast enhancement, voice softening, and face softening which were some of the main goals of transitioning for the girls. The theme of transitioning is significant to the lived experience of trans youth accessing trans-related healthcare because it allowed them to live authentic lives. Access to trans-related healthcare, therefore, leads to hormone use, surgery, and counseling services enabling transitioning.

Self-Fulfillment

Being able to access trans-related healthcare (hormones especially) was arguably the most important thing for the participants. All participants were happy and

comfortable in their female self after accessing or while accessing trans-related healthcare. The reasons given by the participants included aligning their perceived gender and their sex and thus reclaiming their lives, feeling beautiful and attractive, and transitioning was fulfilling. The self-fulfillment was a result of transitioning that was facilitated by access to trans-related healthcare services. Transitioning also spurred transphobia from the non-trans community for some of the participants but did not deter them from leading authentic lives. The following are some of the accounts of the self-fulfilling experience that being able to access trans-related healthcare that enabled transitioning, had for the participants.

For one of them, transitioning was matching the outside to match one's inner self and after transitioning, *"Everything fits now. People will address me as she, ma'am, her. It fits. It works"* according to another participant. For one other participant, accessing trans-related healthcare that facilitated transitioning gave her a chance to live and to reclaim herself and her own life. She said:

Honestly, it means like another chance to live, really... And so it's like I get a chance to reclaim myself and be who I want to be. You know, you're born with a gender and with a name given to you, and you can't help what name you're given or help what gender you're given, but when you're given the opportunity, I guess, to be who you want to and like you get told that if you know you're a woman, then there's no one stopping you from being that woman that you know you are. And so to be able to go and get hormones, especially like with my insurance covering it, and to be able to live my life the way I want it and go by the name that I want to and wear

the clothes that I want to and style my hair and do makeup the way I want to, it feels good. It feels really, I don't know, rewarding in some way, because I feel like in my life I know I did something, I know I reclaimed something my own, my own life. [Participant # 5]

The participants were generally very passionate when they spoke about the meaning of their transition/accessing trans-related healthcare and they all seemed genuinely happy talking about how they felt. One of the trans women while expressing her appreciation for the opportunity to access trans-related healthcare said:

If I didn't get this opportunity, I mean, you know, I would still be living, obviously, but I could honestly say I wouldn't be living as happy. I wouldn't be living it to the fullest. Like I feel like I finally – I found my purpose. Like before I never really knew what I was going to do. I never saw my future really. I just kind of lived day-by-day, and if I didn't get to do what I'm doing now I would so be just living day-by-day and I wouldn't be happy. And I would be forcing myself to move on every day, you know, and deny myself of my true rights, you know? And I feel like now that I've been able to do what I wanted to, like I've got to accept myself.

[Participant #4]

For one participant who felt transitioning was fulfilling:

...it just feels good to know that you're passable. You can walk on the street, and people look at you, and you get referred to as a girl everywhere you go, "Thank you, Miss." "Can I take your order, ma'am?" "Thank

you for calling, ma'am," all that, it feels good. Then, the attention from the guys is amazing, I love it. [Participant #9]

Most of the participants felt beautiful and attractive after taking hormones. Two of the participants claimed they were able to date the straight men they wanted after transitioning and this was a dream come true for them. There was unanimity among the participants that hormone therapy was fulfilling and this seemed to be the essence of their experience accessing trans-related healthcare.

While transitioning put a smile on the faces of all the trans girls interviewed, many of them felt that they were treated unequally and had been victimized for being transgender. Some of the participants reported that they had been picked on for their voices. For most of the participants, living as a transgender girl was a rough life and even worse than living as a gay person according to one participant. One victimized trans girl was not deterred by the bad experience however:

I've been stabbed twice, and I've been into a lot of fights with men, not just the inside community but the outside community, and it's dangerous. It gets really dangerous. Sometimes I fear for my life, but you look for the positive in it and you keep pushing and you keep going and you keep telling yourself, "I can do it, I can do it, I can do it". [Participant #2]

The trans girls all seemed to show a lot of resiliency amid the violence they lived through.

The second theme, self-fulfillment, was the perceived positive outcome of transitioning after access to trans-related healthcare (hormone therapy especially). The participants felt womanly, beautiful, attractive, happy, and empowered, from their ability

to transition that was facilitated by access to trans-related healthcare. The theme of Self-Fulfillment is essential to accessing trans-related healthcare because it gives the trans participants a perceived chance to live authentic lives and to reclaim themselves and their own lives. The participants' decision to seek trans-related healthcare and the satisfaction gained from transitioning were well emphasized by the participants.

Trans Community Solidarity

Accessing trans-related healthcare gave the trans participants a chance to transition and become transgender individuals. As trans individuals, the participants became part of a closely-knit minority trans community due to their shared experiences of accessing trans-related healthcare. The participants found other trans people they could relate to and they forged family-like bonds with other trans people. The LGBT Center was a meeting point for many of the participants and they were able to get information about trans-related healthcare resources from the center. From their shared experience of accessing trans-related healthcare, the participants formed very strong relationships that would not have been possible without the opportunity for the participants to share their trans-related healthcare experience while at the LGBT Center and beyond. The ability to connect at the level of shared experience accessing trans-related healthcare among the participants was fundamental in the development of the theme of solidarity. The participants spoke highly about solidarity in the trans community helping them in mitigating the weight of stigma and discrimination they suffered post-transitioning.

Many of the participants described the role of the trans mom and also their life as a community. Four of the participants had a "trans mother" or "gay mother" described as a transgender woman who had been transitioning longer and stable financially. A trans

mom was also described as someone who advised those transitioning on how to be independent women and helped to empower the trans women in the study. The trans mom also gave direction and advice on how to access trans-related healthcare services (hormones, doctor's appointments, counseling, and surgery) given their experience doing so and often took some of the participants to providers of trans-related healthcare services. The participants reported learning so much from their trans moms with whom they were in close communication.

Without them [Trans moms], I wouldn't have learned a lot of things that I learned out here like how to take care of myself or how to be independent or how to just keep your feet on the ground. With my sisters out here as well. Me, my gay mother, we talk every so often, because we're on two different types of cities. But every chance that I get, I do love talking to her. I miss her a whole lot, because we haven't spoken in a while.

[Participant # 6]

For most of the participants, the sense of family and companionship was what they enjoyed from the relationship with their trans mom and it was one of the ways they used to cope with everything negative (transphobia) coming their way as a result of them coming out and transitioning (hormone therapy mostly). Some of the participants mentioned enduring post-transition victimization including being raped and stabbed, being photographed and put on social media and ridiculed. Coping with such traumatic experiences was implicitly linked to being part of a community where shared experiences were common.

The participants all highlighted transgender community solidarity which for many was worth fighting for as they saw one another as family.

And you have a family out here that you don't know, but you hang out with on a 24/7 a day, and they understand you and they take care of you and you take care of them, and it feels good not to be by yourself.

[Participant # 7]

They reported shared experiences with one another and alleged to understand one another in what looked like a symbiotic relationship. Many were also willing to fight for and with other trans individuals no matter the circumstance, despite their differences. They reported sticking together amid the transphobia that most of them reported experiencing:

When it comes to if there's problems, like if you know one particular girl out here that she's fighting somebody random, one of us, like myself, will step in and fight by her side, whether if I know her or not. I know I shouldn't be doing that, but it's the right thing to do to stand with your girls or with the LGBT community, with your family basically... Whether they're wrong or right, you still fight by your family's side, no matter what.

[Participant #2]

Some of the disagreements that some of the participants mentioned that existed among the trans youth community included competing with one another for men, and competing over who was the best dressed and groomed. They however would not allow these differences

in opinions and preferences to stand in the way of their perceived common enemy: transphobia.

The third and last theme, Trans Community Solidarity was conveyed in the lived experience of the trans women in the study. Clearly, the participants all recognized the challenges they faced as a community and were willing to fight for one another. A great degree of sisterhood was conveyed by the participants. Hanging out with one another every day, sharing similar experiences, helping one another with trans-related healthcare resources, helping the young trans girls in transition with survival tips and how to be financially independence, and fighting for LGBT rights were all part of the solidarity that the participants in this study discussed. Being able to share experiences especially those related to trans-friendly PCPs and OBGYNs, was important in informing the choices of the participants with their decision to seek care and a perceived sense of satisfaction. These are important components of the domain of demand related to access to healthcare. The theme of Trans Community Solidarity is an important component of the lived experience of trans youth accessing trans-related healthcare because accessing trans-related healthcare facilitated transitioning and transitioning was a huge window into integrating the trans community that served as a support system for the trans participants.

Chapter Five

Discussion

Reflection on the Findings

The following chapter discusses the study results, limitations and strengths, and the clinical implications.

The findings clearly show that trans youth seek trans-related healthcare in order to live fulfilled lives. For the participants in the study, transitioning—despite all its challenges—was a perceived chance to reclaim their lives, a chance to live again, and for some, to find their purpose in life. These views seem to capture the overall essence of the phenomenon. This finding is consistent with two studies that concluded that trans individuals seek medical and mental healthcare for multiple reasons and are uniquely dependent on medical treatments to realize their identities and to live healthy, authentic lives (Gage, 2015; Shipherd, Green, & Abramovitz, 2010). In fact, access to transgender-related medical services that would allow participants to pass in their chosen genders was their highest medical priority (Bradford et al., 2013). One Canadian study of non-prescribed hormone use and self-performed surgeries transitions in transgender communities in Ontario, Canada, concluded that for many trans individuals in general, medically (and socially) transitioning was important and necessary to maximize health and personal safety, psychological well-being, and self-fulfillment (Rotondi et al., 2013). Transitioning is the period of time during which trans individuals change their physical, legal, and social characteristics to the gender opposite that of their biologic sex. Transitioning may also be regarded as an ongoing process of physical change and psychological adaptation which may involve changing one's identity on legal documents

and coming out to family, friends, coworkers, and others (Vargo, 1998). The decision to seek trans-related healthcare (hormones and surgeries) and the perceived satisfaction associated with accessing healthcare services are integral to the domain of demand, a component of healthcare access.

Transition-related healthcare includes the use of psychotherapy, hormone therapy, and/or surgical procedures for treating the psychological diagnosis of gender dysphoria (Kurzweil, 2014). All but one of the participants used hormone therapy prescribed by a primary care provider (PCP) or OBGYN at a clinic, or they received hormones while in prison. Only one participant did not use hormone therapy out of choice. Having access only through PCP or OBGYN-prescribed hormones is unique in that it differed from previous studies where non-prescribed hormone use was prevalent in the U.S. (Clements-Nolle, Marx, Guzman, & Katz, 2001; Garofalo et al., 2006; Sanchez et al., 2009; Xavier, Bobbin, Singer, & Budd, 2005; Xavier, Honnold, & Bradford, 2007).

While some of the participants made references to some girls who used non-prescribed hormones, none of them admitted ever using non-prescribed hormones. While this might be a result of low reporting of non-prescribed hormone use (Rotondi et al., 2013), it might also signal an improvement in access to hormones with the advent of the PPACA (Obamacare), at least in Los Angeles county. In fact, most of the participants went to clinics or hospitals for trans-related healthcare. Most the participants also said that they qualified for Medi-Cal or Medicare which allegedly covered the expenses related to trans-related healthcare. Medicare covers medically necessary hormone therapy for transgender people. These medications are part of Medicare Part D prescription drug plan formularies and should be covered when prescribed. Medi-Cal (an

extension of California's Medicaid program) has been expanded under the PPACA to enable transgender individuals in California to obtain SRS, hormone replacement therapy and other transgender-specific healthcare services (Ettner, Monstrey, & Eyler, 2013; Stroumsa, 2014).

As it now stands in California, SRS is included in California's state health plan (Smith, 2016). Stroumsa (2014) has however noted that current policies (overall and nationwide) denying medical coverage for sex reassignment surgery contradict standards of medical care and must be amended. This is the case despite the most significant change in national insurance occurring on May 30, 2014, when Medicare lifted a 33-year ban on coverage for SRS (Smith, 2016). This study seems to suggest that there is improved access to trans-related healthcare services with the advent of PPACA. Further research might shed more light into this unclear yet seemingly promising picture for the trans community. It might also be interesting to investigate what the seemingly trans-friendly PCPs and OBGYNs in Los Angeles are doing differently and what makes the county of Los Angeles a preferred destination for trans persons.

What seemed unpopular among the participants in this study, however, was SRS. For MtF trans individuals, SRS entails orchiectomy, penectomy, vaginoplasty, labiaplasty, clitoroplasty (Richards, 2013; Smith, 2016). Most participants did not think it would make them "100 complete" females, or feel more female than they were already feeling with hormone therapy, and gave religious reasons why they would not do SRS. For at least two of the participants, it would be going against God if they sought SRS. In fact, only one participant was longing to get SRS. This reluctance or outright rejection of SRS in favor of hormones only by most of the participants is one of the major highlights

of this study. This contrasts a study done by Rotondi et al. (2013) where 3 of 12 MtF participants indicated self-performing orchiectomies (removal of testicles). While this Ontario study suggested that the reason for the self-performed surgeries was due to a lack of access to trans-related healthcare services (insurance did not cover SRS), in addition to inadequate or lack of financial resources and inadequate training of the healthcare providers, nothing in the study suggested that the participants preferred or wanted SRS. It might be interesting to know if rejection of SRS was only for personal religious beliefs as the current study suggests or there might be other reasons.

Based on the three phases of transitioning discussed by the participants, it appears there is some attempt at the client level at least to follow the Standard of Care (SOC) developed by the World Professional Association for Transgender Health (formerly the Harry Benjamin International Gender Dysphoria Association (HBIGDA). Among others, the SOC specifies that use of hormones (GnRH and comparable treatments) should give adolescents more time to explore their gender nonconformity and other developmental issues and their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment (Castañeda, 2015; Coleman, 2009; De Cuypere, Knudson, & Bockting, 2010; Knudson, De Cuypere, & Bockting, 2010). The drug treatments' "reversibility" underscores and ensures the flexibility the clients have (Castañeda, 2015). Eight out of the nine participants were taking hormones and some had done so for about two years. They also talked about meeting with psychiatrists and psychologists prior to hormone use and prior to SRS for the one participant who longed for it. Access to peri-transition counseling is crucial and meets SOC. The participants in this study seemed to

be able to access this component of care as they transitioned. Whether this was peculiar to Los Angeles only, might be worth investigating.

One significant finding in the study was transgender community solidarity. This was exemplified at individual and general levels. Individually, the role of the trans mom (play mother, gay mother) was highlighted. This is a transgender woman who has been transitioning longer and has much more stability in her life, and guides the young trans individual with the process of transitioning. This is perhaps the first study in which the role of the trans mother (especially vis-à-vis transitioning) was clearly described by the participants and thus provides new insight on the role of family support or lack of support in the lives of trans youth. A core feature of involvement in a transgender community is the shared experience of stigma (Nuttbrock et al., 2015). It would appear that the support enjoyed by the trans youth participants from their play mom, mitigated the effects of transphobia that they reportedly experienced from transitioning.

In the face of hostility, a transgender person's success hinges on receiving critical care, family and social support (Israel, 2005). The participants in this study also described the sense of family and companionship that characterized their lives in Los Angeles County. In fact, some of the participants were willing to fight with and for any member of the LGBT community if under assault whether or not the LGBT individual was right or wrong. Nuttbrock et al. (2015) note that resiliency in the trans community is a new area of research. In fact, a few studies do suggest that the effects of stigma on psychological distress may be moderated by aspects of involvement with trans peers (Barr, Budge, & Adelson, 2016; Bockting et al., 2013; Graham, 2011; Grossman, D'Augelli, & Frank, 2011; Moody, Fuks, Peláez, & Smith, 2015b; Nuttbrock et al., 2014, 2015; Singh, 2013).

Nuttbrock et al. (2015) discovered that involvement in a community of peers with shared experiences of gender abuse appeared to protect transgender women from the depressogenic effect of transphobic abuse. In a study examining resilience among trans youth of color in the southeastern region of the U.S., Singh (2013) discovered that the degree to which transgender participants interacted with other LGBTI youth influenced their resilience. Furthermore, Bockling et al. (2013) suggested that a sense of pride associated with being transgender and perceptions of support from transgender peers buffered the impact of lifetime stigma on current psychological functioning. This finding has important clinical implications which are discussed after the limitations and strengths.

Study Limitations and Strength

This study had some limitations. First of all, the findings of this study reflect only the voices of the trans youth participants in this sample and do not represent the views of all trans youth. However, the goal of qualitative research is not to generalize study findings. The goal of this study was to authentically describe the individual experiences of trans youth accessing trans-related healthcare with hope of having transferable findings. Transferability of study findings is therefore what is applicable here as the findings could be transferred to other similar trans youth participants and contexts in practice and research. It should also be noted that this study was conducted in an urban area (Los Angeles County), where access to trans-related healthcare seems to be better than in rural areas. It would be interesting to explore the experiences of trans youth accessing similar services in rural areas. Lastly, the research assumptions are both a potential limitation and a strength of this study. The assumptions were clearly identified and stated at the beginning of the study. In addition, the bracketing diary helped with

spelling out biases coming from assumptions. This was useful in guiding the interview as there was a conscious effort not to ask questions that pertained to the assumptions.

Bracketing thus was a strength of this descriptive phenomenological study.

Implications

This study suggests that developing a trans person's sense of belonging to the trans community can be enhanced by helping them develop their transgender identity. This in turn potentially has the ability to improve mental health and thus quality of life for trans individuals. Social support has been shown to be an important suicide protective factor and this is relevant given the high incidence of suicide ideation and attempts among trans individuals. Suicide protective factors are those factors that either lower the risk or prevent suicidal behaviors and do not necessarily mean the sheer absence of risk factors nor are they the sheer opposite of risk factors (Moody et al., 2015b; Rutter, 2008; White, 1998). Healthcare professionals should thus always be affirming of trans clients' own identities by using appropriate language, exploring and normalizing trans identities and gender transitions (Barr et al., 2016). An important target for intervention should be a conscious effort to increase trans people's sense of belonging to the trans community.

This study also highlights the unprecedented role of the trans mom. Health care professionals could employ the services of trans moms during group therapies and trans moms could equally be of great help when it comes to public health interventions related to risky sexual behaviors that most young people face especially trans youth.

Lastly, it is very important for any health care professional to recognize the significance of transitioning in the lives of trans individuals. Transitioning was important

in that it helped in aligning the participants' gender identities and physical bodies, but also in allowing others to see and interact with the participants in the ways that were consistent with how the participants saw themselves. Access to trans-related healthcare and transition does indeed save lives and health care professionals must make sure they do not contribute to an already oppressive system that puts access barriers for trans individuals (Moody, Fuks, Peláez, & Smith, 2015a). A conscious effort of advocating for trans individuals' trans-related healthcare resources by all healthcare professionals and policy makers thus seems logical and the right thing to do.

Conclusion

This study identified three major themes (transitioning, self-fulfillment, trans community solidarity) as they pertain to the lived experience of trans youth accessing trans-related healthcare in Los Angeles. Transitioning was of utmost importance to the participants as it allowed them to live full and authentic lives, and trans community solidarity was very important in mitigating the stigma faced by trans youth. It is imperative that healthcare professionals and policy-makers ensure timely and efficient access to trans-related healthcare resources for trans individuals.

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Appendices

Appendix A: List of Significant Statements

Significant Statements	Transcript No.	Page No.	Line No.
<i>"I was a boy at that time. I was still trapped in a girl's body though. I was a boy, but trapped in a girl's – I was a boy trapped in a boy's body, but I knew I wanted to be a female"</i>	1	1	36-38
<i>"It was hard trying to be something I wasn't. I didn't like women, I never did."</i>	1	2	10-11
<i>"I got picked on for my voice"</i>	1	2	16
<i>"I had people that made a little fun of how I talk"</i>	1	2	19
<i>"I could say being a transgender, it's tough, because people they treat you, they judge you, they treat us different, they don't treat us the same as they should a regular person... being a transgender, it's a lot of work that we have to go through. A lot of struggles, a lot of sacrifices that we have to make."</i>	1	3	19-25
<i>"I left my family, I haven't seen my family in eight years because I made a promise before I left Arizona that I wanted to become a woman, I wanted to get my titties, I wanted to get my name changed and I wanted to get stuff done before I went back to New York City so my family would be able to accept me."</i>	1	4	27-31
<i>"I'm just living my life and being happy and being comfortable being a person that I always wanted to be since I was a kid."</i>	1	4	21-23
<i>"Since I've been taking them, I've been – it makes me feel more womanly, more, you know. I see a little progress, my titties' grown, my skin is more softer."</i>	1	5	6-8

<i>"I have my days where I can kind of trip out a little bit because the hormones make you trip out a little bit."</i>	1	5	8-10
<i>"You could see the glow and people, when people take the hormones you can tell the difference. You could tell a lot of difference about it."</i>	1	5	16-18
<i>"I feel fulfilled, yeah. But I really want my pussy, that's the next step. I'm driving for one. I had to get my name changed and my sex change on my ID, I want to get my pussy for me, because I really want to be a woman. I'm not doing it for nobody else, I'm doing it for me, this is what I always wanted to do when I was younger. And I really want my pussy, I really want my pussy, I really want to be able to have it."</i>	1	5	20-26
<i>"so far things been good for me. The hormones have been working, the healthcare, every resource that I took they worked out a lot good for me and I'm just blessed that I just want to see more progress and see more work and see me become a more better woman than I am to this day."</i>	1	6	15-19
<i>"I feel halfway accomplished until I get my pussy and my name and stuff changed. Once I get that done, then I'll really feel accomplished. "</i>	1	6	22-23
<i>"I want to be the ones that can be able to go to the straight world and deal with real people and nobody judge me or nothing, or look at me different. That's why I want to get all this work and stuff done so I could be able to be – people would be able to take me more serious in society."</i>	1	6	28-32
<i>"I'm one of the girls that's serious about this. This dedication and hard work, sacrifice, you know. I left family for this, so <u>I'm really dedicated about being a woman.</u> "</i>	1	7	3-5
<i>"It's been really good, you know. It's been interesting. I get the guys that I want now. I get</i>	1	7	9-15

straight guys, so it's like – it's real good, I can't complain. I can't complain. It's a wonderful feeling; I get the man that I want. I've been in like three or four relationships already, you know. So it's a blessing. I run across a lot of guys and it's just a dream come true because I'm beautiful and I'm attractive, so I get what I want, so."

"I put my whole life on the line for this and I will be damned if somebody disrespect me." 1 8 26-27

"I don't know what would happen to me if they didn't have the resources for us to get titties or stuff to help us become more of a woman and look [inaudible] and beautiful, so it's a lot. I don't know what I would have did. I would have – I think I would have went crazy, I would have went so crazy. I don't know, I don't know. I really don't know." 1 9 13-18

"I still want to find out before I make that decision of me getting a pussy, I want to know if I could still get wet down there, I want to know all the resources and stuff. I'm still looking to find out." 1 10 16-17

"I was trying to – I was being somebody that I wasn't. And now that I'm a woman, I feel comfortable and I'm me... I'm serious about being a woman, you know." 1 11 12-16

"It's been good. It's been a blessing. It's been – I finally get the men that I want, you know. I can't complain. You know I go shopping, I live my life like a regular woman, so it's good." 1 11 18-20

"Being a woman for me is being just I want to be a woman. It's not for the men or nothing, it's just being me and being comfortable with the person that I am inside." 1 11 30-32

"The hormones, they really mess with you physically and emotionally, you know. So it's 1 13 13-26

like you're taking women's testosterone inside your body, so it's like your body is going crazy. It's like you have a mine a frame of a man, but then once you take the hormones, like a mind frame of a woman, so it's just like you're fighting what you want more, the man testosterone or the female testosterone. So it's like it's a lot. You know. And once we take hormones, we can't have sex, we can't get hard no more. The peepee stays soft. Titties get bigger, but if you do come, the titties start getting smaller. So it's like a – there's a downfall and it's a good thing. You know, it's like a bad thing or a good thing. It's a lot to do with the hormones, you know. So if you're serious about being a woman and taking your hormones, you can't be able to come."

<i>"The only thing that I hate about this is that we can't have kids. Which I love kids dearly. But we could adopt some. That's a good thing. But I really hate that we can't have kids."</i>	1	14	12-15
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<i>"I should have just have saved one of my seeds before I came to become a woman so I could have at least a child for my mom, a grandchild."</i>	1	14	28-30
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<i>"I just want the world to understand that transgender people, we're still human. We have heart and we just want to be respected in this world and we want nobody to look at us different. I want everybody to see us as human beings, and we have a heart. And I want everybody to start taking us seriously."</i>	1	16	21-25
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<i>"Yeah, so that's been my tough challenge like trying to be accepted in like a regular work environment or a regular everyday life that I am by being judgmental and a different outlook or give me their opinion when it's not called for...Negative reactions towards how I choose to identify or live my life."</i>	2	2	11-18
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<i>"I think it's knowing who you are [inaudible] according to yourself, according to your identity"</i>	2	3	11-13
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and becoming more aware of your inner being, your inner spirit.”

“It made you feel more at peace with yourself, like you're in the process of becoming 100 percent of who you are.” 2 4 10-11

“My family is Hispanic and European and Black but they don't – they're more minority-based racists so it was tougher.” 2 5 13-15

“So to me it's fun but it's a hard life to live.” 2 6 21

“So it's a hard life to live because you can't just push your opinions on people. To me I feel like you've gotta be honest and let people you date, you have to let them know off the bat so then they won't have nothing to hold against you saying they didn't have an idea or they didn't know... to me [inaudible] it's a hard life but you have to be open.” 2 6 27-34

“I've been victimized but I grew up on the streets so I can victimize back. It's just great. No, I feel like if they victimize me I victimize them back. I definitely had my fair share of people using the negative expressions towards the community upon me, like how their negative views and their negative.” 2 7 6-10

“And I've been luckily smart enough lately to calm myself down [inaudible] to react to [inaudible] difference being different to how they view me. So I've been trying to teach myself how to be more open to the fact that people have their own separate opinions about transitioning and trans issues than I do. And I've been very, very, very, very, very, very likely to remind myself that just because a girl or somebody doesn't know about trans issues, I shouldn't be mad.” 2 7 8-15

“I hate when guys go, I want the real vagina. Like if you're in a relationship and they're like, oh, I want a real vagina.” 2 7 22-30

<p><i>“you have to be a drug addict just because you’re atrans or you're a prostitute. Like I can't just walk to a store. I have to be a prostitute walking to a store. And I'm just like, why? Oh, because you're a tranny and we all know they all prostitute and use drugs. So it's just like, no, that's not true or like you have to be certain things due to the fact that you're a transition or that you're a transgender.”</i></p>	2	7	30-40
<p><i>“<u>When I did it I didn't really feel any different except for when your hair and] stuff grows in you get a [inaudible] and it hurts then [inaudible] that means your boobs are gonna fill out. But other than that I didn't feel any different. I had new hair [inaudible] growth and they go, oh, you get your period [inaudible] act like a bitch for like a week. And I go, that sounds like an excuse so I never had any of those issues. But if you stop doing it you get this issue of it's a weird odor that happens because it's your testosterone fighting back to push out the estrogen. So that's about the only two things I got in different from the other.”</u></i></p>	2	8	11-21
<p><i>“It makes you feel – for me it makes me feel more at peace. I just like the feminization of it, the more softness of it.”</i></p>	2	8	23-25
<p><i>“I'm not sure if I plan on doing surgeries...I feel like that's saying you're playing around with God and you're changing the way he made you. I don't know if you get it.”</i></p>	2	11	18-23
<p><i>“I feel like it's one thing [inaudible] guys have breast plates. It's just about making them bigger or smaller with the hormones. But I feel like it's different when you go and remove things. <u>So to me I don't feel like – I don't know if I'm gonna get surgery or not.</u> I think I just might take hormones because hormones are supplements. So to me it's natural.”</i></p>	2	11	25-30
<p><i>“I've been like this my whole life. I had no work done. It's just who I am. I don't know, I'm a male shell with a female [inaudible].”</i></p>	3	4	24-26

<i>Oh, my god, the disrespect, the – I mean, it's rough. <u>I mean, being gay is different but being trans is, oh mygod, worst.</u></i>	3	5	19-20
<i><u>"They'll take pictures of you [inaudible] and post them on Facebook and [inaudible] – [inaudible] lose control of yourself and maybe you start doing drugs and [inaudible] commit suicide."</u></i>	3	6	10-14
<i><u>"Actually, I just start hormones a month ago, and I don't know. I feel more comfortable with myself because at first, I was just a boy. Basically, the inside of me was a girl but trapped inside a boy's body, but now, I feel more of who I am because of the hormone therapy."</u></i>	4	2	12-16
<i><u>"People around me, some people are supportive, and some people are just don't like it, but it's not up to me. It's not for them to have me live my life. I'm gonna live my life how I wanna live it. I mean, if they don't like the fact that I'm on hormones, then I can't help but not pay attention to that because I don't want people running how I live. I don't want people disliking me because of who I am, so I just kinda say to myself, "I'm a really friendly person. If you don't like me, then I just suggest you don't say anything to me or don't talk to me." Other than that, I have love for everyone."</u></i>	4	3	29-39
<i><u>"A lot of real girls will be like, "That's a boy," and some other guys will be like, "That's a boy," and I just don't pay attention to any of that. I just walk past them as if I didn't hear what they said."</u></i>	4	4	13-16
<i><u>"Well, I just feel kinda a little disrespected because they don't understand whatever that is I'm going through, and for me to be whatever I am, and for them to call me what I'm not or what I don't prefer to be called, yeah, a little, but I just don't let it get to me."</u></i>	4	4	20-24

<i>"Yeah, I was thinking about it, but I'm not sure if I wanna get surgery or not. I think natural hormones is just what I want, no surgery."</i>	4	6	22-24
<i>"it's just hormones and the hormones that's mixed with me being on my side of my family and just the hormones, so surgery would be like, "Dang, you put in extra work just to look like that?" I mean, I'd rather look like something from my family's side than something that other people want me to look like."</i>	4	6	27-32
<i>"I feel more better...when I finally got a chance to get my hormones, I feel more of myself because now I feel that, "Okay, well, now I have titties. Now I feel more like a girl.""</i>	4	7	5-10
<i>"I know what it feels like to grow up as a boy and alsolive as a girl, but it's hard to explain it to anybody else because – well, for me, it's just growing up being a boy knowing that I wanna be a girl, but <u>now that I have the chance to live my life as a girl because of hormone therapy, I feel more like a girl.</u>"</i>	4	7	29-34
<i>"Being transgender for me is just me living a lifestyle as a girl, but I know deep down inside, I was born a male, and I like that. I don't know about anybody else, but that's how I feel, and that's what I know."</i>	4	9	34-37
<i>"A lot of people think there's a meaning to it, like, "Oh, that's a faggot being a girl," or, "That's a boy being a girl." No, it's not that, it's what they know – it's a lifestyle. They know what they are when they were younger, and <u>now that they finally got a chance to be what they want, that's a lifestyle, not a meaning.</u>"</i>	4	10	13-17
<i>"The only person that I've been close to is my play mother...A play mom, just someone that you call your mom that will be there for you and take care of you while you're transforming."</i>	4	11	20-24
<i>"She's also a transgender woman. She takes me to all my doctor's appointments. If I have any</i>	4	12	5-10

questions, just because she's been transforming longer than me, I just ask her, and she'll let me know, like, "Oh, that's fine, that's okay." If she don't know, then she'll be like, "Okay, we'll go to the doctor and ask." She's just always been there for me through me transforming."

<p>"Well, I'm just like anybody else, any other human being. I feel like everyone should be treated as one and equal, and we shouldn't have to discriminate or put anybody down. We should always help each other and bring each other up."</p>	4	14	22-25
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<p><u>"I've also like really become comfortable with myself to where I can live every day and go outside of LA and still be happy with myself. And so, I mean, I'm happier with my transition now. The beginning was rough and it was like something I had no clue how to make it through and I have gone through a lot of obstacles to make it to where I am now. I am still building, definitely, and getting used to it more and more."</u></p>	5	3	16-22
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<p>"We're like a community and we love each other, but at the same time there's a lot of hate too, but that's – a lot of arguing with each other comes from the hate on the outside, and we don't have anybody else to take it out on, because we're the only ones like ourselves. That kind of becomes a struggle when I have to face other trans women who may or may not like me."</p>	5	3	29-34
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<p>"I've had struggles with people yelling at me, like, you know, calling me a man or like telling me that I'm doing something wrong or telling me I'm going to get killed one day or something like that. So it's a lot of struggles people warn you of or that you go through. But they're gotten easier as I've gotten stronger and more comfortable. People leave you alone more."</p>	5	3	37-44
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<p>“I worked at [xxx] for the last seven months, and I don’t work there now, I just quit. Just like because a lot of personal issues, <u>like just going through emotional issues, because that’s another thing when you’re taking estrogen, your hormones and your emotions get so much harder to deal with.</u> And some people can make them go crazy, like literally crazy.”</p>	5	4	27-33
<p>“But it gets a little overbearing sometimes. So there’s a lot of struggles, emotions, the cars, other girls, people not being okay with trans, and I don’t know, just like the ultimate element of it being hard to get a job also. Like I was lucky to get a job as a trans woman, but a lot of trans women do face like the struggle of not being accepted in the workplace, or at least not being able to be who they are or want to be in the workplace, so.”</p>	5	4	35-42
<p>“I hate feeling uncomfortable because, I mean, it’s me, I should be able to live the way I am. <u>But you do get uncomfortable every once in a while</u> when they say that. It makes it hard to keep going. <u>And that makes you really emotional sad,</u> but I’ve kind of gotten – I mean I’ve learned to kind of ignore it.</p>	5	5	10-15
<p>“If I’m walking on xxx Boulevard and someone says like, “Oh, that’s a man.” Like I just learned to laugh it off now and just like – you know, <u>it still hurts and it still makes me feel a little shitty about myself.</u> But at the same time I know who I am and who I’m happy being. And so it’s like I can’t really let their comment get to me, because I know I won’t see them again.”</p>	5	5	17-22
<p>“I just got my family back in my life, and I just went and visited them actually a month ago...I saw all my friends from high school and everyone, and they all accepted me. It was the best feeling in my life. The most rewarding feeling. And so I have them as a support system.”</p>	5	5	31-36

“Honestly, it means like another chance to live, 5 6 35-52
really. You know, because, I mean, one thing
I’m most proud of is my legal name is Chance,
and so now my name is Hope now. So I was like
a Chance at the past, but now it’s like my Hope
for the future. And so it’s like I get a chance to
reclaim myself and be who I want to be. You
 know, you’re
 born with a gender and with a name given to
 you, and you
 can’t help what name you’re given or help what
 gender you’re given, but when you’re given the
opportunity, I guess, to be who you want to and
like you get told that if you know you’re a
woman, then there’s no one stopping you from
being that woman that you know you are. And
so to be able to go and get hormones, especially
like with
my insurance covering it, and to be able to live
my life the way I want it and go by the name that
I want to and wear the clothes that I want to and
style my hair and do makeup the way I want to, it
feels good. It feels really, I don’t know,
rewarding in some way, because I feel like in my
life I know I did something, I know I reclaimed
something my own, my own life.”

“If I didn’t get this opportunity, I mean, you 5 7 17-29
know, I would still be living, obviously, but I
could honestly say I wouldn’t be living as happy.
I wouldn’t be living it to the fullest. Like I feel
like I finally – I found my purpose. Like before I
 never really knew what I was going to do. I
 never saw my future really. I just kind of lived
 day-by-day, and if I didn’t get to do what I’m
 doing now I would so be just living day-by-day
 and I wouldn’t be happy. And I would be
 forcing myself to move on every day, you know,
 and deny myself of my true rights, you know?
And I feel like now that I’ve been able to do what
I wanted to, like I’ve got to accept myself. And
 even if other people don’t accept me, like I
 [inaudible] myself enough to do the move and to
 allow myself to transition even with everyone
 telling me no.”

<p><u>“You know, the first six months of my transition were probably the hardest six months of like I think in my whole life, because I was dealing with a really strong mental battle. Like, it’s hard to explain. Like I knew it was what I wanted, but I didn’t know if I had the strength to keep doing it every day. I didn’t know if I had the strength to put my body through a transitional process that is almost irreversible, especially for someone who is in a home less situation like me. You know, there’s no going and getting surgery through things or things like that, and so it’s like the decisions I make are irreversible and so before I started estrogen, before I started actually taking it and I was transitioning just like by changing my outfits and changing the way I presented myself to people, I was just thinking like, am I doing the right thing? Would I have made it farther in my life if I hadn’t transitioned?...And then, you know, I really wanted to know, will I look pretty or are things going to like happen the way I want them to happen and I was really scared. In the first six months I really was in that questioning phase, like, is this right? Am I going to do this? Am I strong enough? Can I handle what everyone’s going to so say? Can I handle dealing with it for however long?”</u></p>	5	7	35-52
<p><u>“For me it’s not a choice. I don’t know, I can’t – I don’t know, like I can’t go back to being like and man and ignore what I ever want to be.”</u></p>	5	8	35-37
<p><u>“...there’s a lot of girls I know who will buy it from like Salvation Army or go buy hormones, just a shot, like go buy it from off the streets. Girls buy shit hormones off the streets all the time and just inject themselves, and they don’t even know how to do it or they use the wrong needles, like a tube, because there’s different types of needles.”</u></p>	5	15	1-6
<p><u>“It’s been rocky, but it’s been good...It’s just as far as me being comfortable with my skin and me figuring out where – what I’m going to do after</u></p>	6	1	27-34

the transition and stuff like that...Yeah, somewhat. It's been easy, but it's been kind of hard just – it's really just adjusting from me being a certain way to me being a different way."

"Really I've just been dressing more like a female, wearing hair, nails, makeup. I'm not on hormones. I don't want to be on hormones and that's about it for right now."

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8-10

"It makes me feel good. There's some days I kind of belike uh, but overall I'm pretty satisfied with my decision."

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3-4

"They usually expect that I'm a prostitute, but I'm not. That's about it as far as them thinking I prostitute, but I don't."

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6

27-28

"It's been a hell of an experience, having to go through the trouble of finding out where to go, get your hormone therapy for free. It's a real emotional and mental change. They start to trick your body into making it – it feels like that you think you're pregnant, kind of. One minute, you're fine, having fun with your friends, and the next thing you know with that same group of people that you were just having fun with, you're depressed, and you wanna cry, and you just wanna be alone. The mood swings are a bitch to deal with."

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2-10

"At first, coming out as a transgender person is awkward, I wanna say. If you think you have a lot to deal with about coming out just about being gay, it's something completely different having to deal with coming out about being transgender because it's not a physical thing. It's not your body, it's not you're born a man and you're trying to live as a woman, it's you're born a man, but your mental state is that of a female's. Everything you like is all girl stuff. "

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11-18

"At the same time, it's very fun, to be honest. I love the attention that I get. I know it seems like

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27-36

a lot of us glorify that we see attention that we want, but it's fulfilling, it is.

Not that it matters what anybody thinks about you, it just feels good to know that you're passable. You can walk on the street, and people look at you, and you get referred to as a girl everywhere you go, "Thank you, Miss. Can I take your order, ma'am? Thank you for calling, ma'am," all that, it feels good. Then, the attention from the guys is amazing, I love it."

<i>"I like it. I just like it. I love the transition that I've made in my life. <u>I love the fact that I started this, and plan on continuing on with it for the rest of my life. I finally feel comfortable in my body. I finally feel comfortable to walk outside in a pair of shorts and a tank top. It feels good to be able to walk down the street and look at your reflection in a window from a store or something, and you look and you're like, "Damn, is that me?" It just puts a smile on my face. I love it."</u></i>	7	3	4-12
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<i>"We stick together, for the most part. We may not like each other all the time, some of us may not even speak to each other, but if I see one of them going through something like that that I went through or something similar, I'm gonna get in the middle of it and I'm gonna do what I can to stop it because nobody deserves to go through that."</i>	7	6	8-13
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<i>"...my transgender mother and her husband, who I call my dad, it's a blessing just to have them in my life at all. These people have taken me into their motel rooms, or their apartments, or their houses, and let me live with them...It may not be a life for everybody to live, but the companionship and the sense of family is really more how I cope with everything."</i>	7	6	17-25
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<i>"My real mother almost completely turned her back on me at that point. I didn't have a family."</i>	7	7	2-3
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<p><i>“My gay mother, my transgender mother, she’s amazing. I love her to death. She’s never let me go without, ever... my transgender mother is the one who’s been able to pick me back up and help me get back on my feet, and talk to me like a mother. She’s my mom. It’s crazy.</i></p>	7	7	10-22
<p><i>“Xxx, come on. Mother and daughter are gonna go have some dinner,” and she’ll treat me to dinner. On Mother’s Day, I actually go out and look for something to buy her on Mother’s Day. She took me in and celebrated my birthday with me last year. She’s also been a good help when it came to the hormones, the hormone therapy and everything. She’s been an amazing help as to who doctors to go to, and has gone with me to my appointments because she’s gone through it, and I don’t know exactly who to expect because I’ve never done it before. I can sit down with her and talk with her about my physical health and know that this is somebody who has gone through exactly what I’m going through now and is able to relate to me on it, and tell me, “This is what I had to do with it. We’ll talk you to the doctor, but they’re probably gonna tell you to do this. For now, just do this, and then we’ll get to the doctor. I’ll make an appointment or whatever.” Like I said, she’s been an amazing help. That’s my mom.”</i></p>	7	7	27-45
<p><i>“The OB/GYN that I spoke to started me on two 1.25milligrams of premarin every day, and from there, it was just a lot of sitting there and waiting, just waiting for a breast to pop out. It wasn’t anything out of the ordinary, from what I’m told. They hurt. When it’s cold outside, they get super cold. Excuse me. They’re real sensitive, they itch, and it’s physical feelings that I don’t like going through, but it’s worth it, though, it really is.”</i></p>	7	8	23-29
<p><i>“Oh, I’m happy. I’m happy with it. I’m happy about the fact that I started my hormones. I’m happy with the fact that I got them, with the fact that things are there.”</i></p>	7	9	1-3

<i>"I guess you could say the way I've acted, the way I've portrayed myself finally fits my physical features. I feel like it's a lot easier to go ahead and be me with this body than it was before, when I was a boy. I feel like it makes some things easier."</i>	7	9	7-11
<i>"As of right now, I don't plan on getting the surgery. I like to be different, so the way I see it, if I go ahead and get the surgery and have a doctor put that specific body part there that God put on a normal girl, then that just makes me like every other girl. I'd feel like there's nothing special about me."</i>	7	9	16-20
<i>"The other thing I was wondering, "Would things be easier if I was still a boy," but then, I think about the good things that I have going for myself, like my boyfriend, and the fact that we're going back home next month. I wouldn't go back and change anything, I wouldn't."</i>	7	10	6-10
<i>"A lot of the places, especially out here, look at the transgender girls. First thing they think of is prostitute, mess, drug addict, problem person. "They're problem people, we don't want them here." I would speak for myself, but I know it's not just me. For us as a collective, it's harder to go and apply for work when that's how they're looking at you, when that's how they look at you and that's how they think about you. We're low-key kinda forced to do the kinda work that we do."</i>	7	10	21-28
<i>"Basically it just means that you are matching your identity of who you are, who you feel, matching the outside to match your inner, basically."</i>	8	1	26-28
<i>"Your inner is who you are. I feel female. I am female, you know what I mean? All around, I feel female."</i>	8	1	30-31
<i>"It's from inside. That's what I honestly say, because you see a lot of girls that will basically dress up, do this and that, but you have to truly</i>	8	2	3-8

feel and know who you are. If you've always felt this way since you were a child growing up like, "Hey, something doesn't feel right. I know I feel like the opposite gender," then you'll know."

"I am on hormones. I am on hormones. Yeah, they give you hormones, they give you the spironolactone pills, which is also basically like help with the hormones. It breaks down all of your testosterone and the buildup and all of that good stuff, so muscles and everything."

8 2 12-18

"You know on the media, like Jerry Springer or something, they'll make us look a fool. They'll have us snatching wigs off, and it's like they just kind of use us as something to laugh at in the media."

8 2 25-27

"For me, when I transitioned, like I said, I always felt who I was. I always knew who I was inside. It was never comfortable for me being around guys and other boys growing up. I was always stand-offish when I had to hang out with the other boys. I was always stand-offish, because I know who I am, and I don't relate. I didn't relate to nothing, basically. You know how it is, all the hyper manly. Yeah, like, okay. And I always imagined my body shapedfeminine, woman. I always had that feel that my body was feminine, woman, that I am female. So that's why I did my transition, because I knew who I was. I knew exactly who I was."

8 2-3 35-45

"It makes me feel actually very great, because I am able to live my life. Honestly, I barely started living my life since I was about 19, 18 or 19, because that's when I came out. That's when I first came out. And before then, I was never talking, I was just a quiet person. Quiet person, because I didn't feel right. I wasn't – it was hard to live life, basically, with people trying to view you and speak to you as a man, because it felt like, "Ew," the whole time."

8 3 6-12

"I am very happy and I feel very great, because I am who I am and I speak, I talk more. I'm

8 3 18-24

actually lively. I feel like I'm just coming to the world only a couple of years ago, basically, because before then I was always sectioned off and quiet. Even during my days of coming out, I still wasn't completely who I was. So I was just getting used to it. But I'm very happy. I am very very happy that I am who I am."

<i>"<u>I actually feel a lot more complete.</u> I mean, I've always felt who I am. Who I am inside didn't change. It did not change, because I've always been the same way, just a different body on the outside. But mentally, I've always been the same way. And this is who I am. Everything fits now. People will address me as she, ma'am, her. It fits. It works."</i>	8	3	27-32
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<i>"It lets me know that, okay, at least people are finally seeing me for who I truly am. That's what it makes me feel. When I hear that, it feels good. It does feel good."</i>	8	3	34-36
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<i>"I'm not going to lie, I have my points where I'm a little moody, but I feel like it's just normal."</i>	8	6	13-14
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<i>"Well my name and gender is about to be changed really soon. I'm taking my papers down to the court on Thursday actually, the Thursday coming up. So I'm going to change my name and my gender, which legally my name will be who I am. So that's my first step that I'm taking. And yeah, I'm just debating. I'm debating when it comes to another surgery, but I'm not sure if I want it or not. You know?"</i>	8	6	21-27
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<i>"I want for people to just start treating us like a normal person that you speak to, especially like let's say you get on the bus. You just have a normal conversation. You can have a normal conversation with a transgender girl too."</i>	8	8	38-41
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<i>"<u>For me, it means that I am able to basically just live and actually live my life and be happy.</u> Like who I am on the outside is matching up with who I am definitely on the inside, and people feel and see that, <u>so now they're treating me</u></i>	8	9	8-13
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accordingly, and it feels great, because that's all that I've ever wanted to hear, and that's all that I've ever felt."

<i>"The positive part about it is you have other girls out here for you, that support you, whether they're your friends, your sisters, even brothers out here, for me,..."</i>	9	1-2	40-43
<i>"I can say one thing that we in the transgender community were, we're all considered sisters. We all do look out for each other, even on a good day or a bad day, and they taught me a lot. A lot of girls that I know out here for four or five years that I've been out here, they've taught me to survive, how to live, how to love myself, and how to accept the things that come to you, whether it's good or bad, and I love it."</i>	9	2	31-38
<i>"I see myself as a girl, with or without hormones. But learning more about hormones and how it enhances you and helps you feel the girl that you completely want to be, it's a beautiful thing. I do take hormones,"</i>	9	3	6-9
<i>"They enhanced more like my skin, hormones, you build a core in your chest, and your core, like, it comes out to be like an actual breast, but it takes a while for it to grow completely out. And to me, it's just more for your feminine features, your skin, of course the breast enhancement and that's pretty much how much I know about it."</i>	9	3	14-19
<i>"Honestly, I can say even without the hormones, I'm still the woman I am, whether they enhance my features without them or not, it doesn't take a hormone to make a woman. Inside and out is how you build your woman, because some girls say, "Well having hair, weave, nails, makeup, and all the things, is what makes a woman," it really doesn't. It's inside what counts. But I can say yeah, they've enhanced me a lot and I love it, and yes, I want to still continue taking hormones."</i>	9	3	28-35

<i>"I'm not going to be 100 complete if I do the surgery. I'm not going to bear a child, I'm not going to feel like, I don't know if you understand. I'm kind of a mix of words, but I'm just going to say it straight forward, I'm not going to be like a biological female, no matter what..., I prefer to be different. I prefer to keep what I have, and because that's my personal opinion. Yes, I consider myself 100 percent woman. No, I don't use my front part, my private part in the front or nothing like that like some trans women do, but most don't, and that's how I leave it as."</i>	9	4	6-17
<i>"It's rocky. I barely started talking to my mom. It's not easy."</i>	9	5	8
<i>"We don't introduce ourselves as trans women, we just introduce ourselves as women, but I have two gay mothers and I have two gay fathers and I love them to death. I love them so much. Without them, I wouldn't have learned a lot of things that I learned out here like how to take care of myself or how to be independent or how to just keep your feet on the ground. With my sisters out here as well."</i>	9	5	33-39
<i>"when it comes to if there's problems, like if you know one particular girl out here that she's fighting somebody random, one of us, like myself, will step in and fight by her side, whether if I know her or not. I know I shouldn't be doing that, but it's the right thing to do to stand with your girls or with the LGBT community, with your family basically... Whether they're wrong or right, you still fight by your family's side, no matter what."</i>	9	6	22-30
<i>"I wouldn't change anything in the world, whether I had a bad day with one of my sisters or my parent or anything like that, I wouldn't change it for the world."</i>	9	7	3-5
<i>"I'm not going to regret, I am a woman, so there's, what's, you know, what's to regret? You live your life as you live your life and nobody</i>	9	7	20-28

else can tell you anything about it but yourself. I don't regret making the choices that I make, whether it's being out here, whether it's being a transgender woman or woman period, I know who I am. Inside and out, I'm a woman. Inside and out I'm a woman and I will never change that. I love myself and I love the decisions that I make because I learn from them. I learn from the mistakes, the lessons."

Appendix B: Formulated Meanings

Significant statements	Formulated Meanings
<i>“I was a boy at that time. I was still trapped in a boy’s body though. I was a girl, but trapped in a boy’s – I was a boy trapped in a boy’s body, but I knew I wanted to be a female”</i> (Transcript 1, page 1, lines 36-38).	Participant felt she was a girl trapped in a boy’s body and wanted to be female.
<i>“It was hard trying to be something I wasn’t. I didn’t like women, I never did.”</i> (Transcript 1, page 2, lines 10-11).	Participant had difficulty being someone else.
<i>“I got picked on for my voice”</i> (Transcript 1, page 2, line 16).	Participant has been victimized for being herself
<i>“I had people that made a little fun of how I talk”</i> (Transcript 1, page 2, line 19).	Participant has been made fun of for being herself.
<i>“I could say being a transgender, it’s tough, because people they treat you, they judge you, they treat us different, they don’t treat us the same as they should a regular person... being a transgender, it’s a lot of work that we have to go through. A lot of struggles, a lot of sacrifices that we have to make.”</i> (Transcript 1, page 3, lines 19-25).	Participant feels judged and treated different for being transgender
<i>“I left my family, I haven’t seen my family in eight years because I made a promise before I left Arizona that I wanted to become a woman, I wanted to get my titties, I wanted to get my name changed and I wanted to get stuff done before I went back to New York City so my family would be able to accept me.”</i> (Transcript 1, page 4, lines 27-38).	Participant is determined to become a woman and leaves family.
<i>“I’m just living my life and being happy and being comfortable being a person that I always wanted to be since I was a kid.”</i> (Transcript 1, page 4, lines 21-23).	Participant is happy and comfortable living as a woman now.
<i>“Since I’ve been taking them, I’ve been – it makes me feel more womanly, more, you know. I see a little progress, my titties’ grown, my skin is more softer.”</i> (Transcript 1, page 5, lines 6-8).	Hormone therapy is making participant feel more womanly.

“I have my days where I can kind of trip out a little bit because the hormones make you trip out a little bit.” (Transcript 1, page 5, lines 8-10).

Hormone therapy makes participant trip a little.

“You could see the glow and people, when people take the hormones you can tell the difference. You could tell a lot of difference about it.” (Transcript 1, page 5, lines 16-18).

Participant feels glowingly different from hormone use.

“I feel fulfilled, yeah. But I really want my pussy, that’s the next step. I’m driving for one. I had to get my name changed and my sex change on my ID, I want to get my pussy for me, because I really want to be a woman. I’m not doing it for nobody else, I’m doing it for me, this is what I always wanted to do when I was younger. And I really want my pussy, I really want my pussy, I really want to be able to have it. (Transcript 1, page 5, lines 20-26).

Participant feels fulfilled with transition but resolute on having a vagina through sex reassignment surgery

“so far things been good for me. The hormones have been working, the healthcare, every resource that I took they worked out a lot good for me and I’m just blessed that I just want to see more progress and see more work and see me become a more better woman than I am to this day.” (Transcript 1, page 6, lines 15-19).

Feeling good and blessed with hormone therapy as participant looks forward to becoming a woman.

“I feel halfway accomplished until I get my pussy and my name and stuff changed. Once I get that done, then I’ll really feel accomplished.” (Transcript 1, page 6, lines 22-23).

Participant feels halfway accomplished until sex reassignment surgery is done.

“I want to be the one that can be able to go to the straight world and deal with real people and nobody judge me or nothing, or look at me different. That’s why I want to get all this work and stuff done so I could be able to be – people would be able to take me more serious in society.” (Transcript 1, page 6, lines 28-32).

Participant desires to lead a life void of judgment is motivation for transition.

“I’m one of the girls that’s serious about this. This dedication and hard work, sacrifice, you know. I left family for this, so I’m really

Participant is dedicated about being a woman.

dedicated about being a woman.” (Transcript 1, page 7, lines 3-5).

“It’s been really good, you know. It’s been interesting. I get the guys that I want now. I get straight guys, so it’s like – it’s real good, I can’t complain. I can’t complain. It’s a wonderful feeling; I get the man that I want. I’ve been in like three or four relationships already, you know. So it’s a blessing. I run across a lot of guys and it’s just a dream come true because I’m beautiful and I’m attractive, so I get what I want, so.” (Transcript 1, page 7, lines 9-15).

Participant feels blessed, beautiful, and attractive as a result of transition.

“I put my whole life on the line for this and I will be damned if somebody disrespect me.” (Transcript 1, page 8, lines 26-27).

Participant put whole life on the line for transition.

*“I don’t know what would happen to me if they didn’t have the resources for us to get titties or stuff to help us become more of a woman and look **[inaudible]** and beautiful, so it’s a lot. I don’t know what I would have did. I would have – I think I would have went crazy, I would have went so crazy. I don’t know, I don’t know. I really don’t know.”* (Transcript 1, page 9, lines 13-18).

Participant thinks that without resources to transition, she will be indescribably unhappy.

“I still want to find out before I make that decision of me getting a pussy, I want to know if I could still get wet down there, I want to know all the resources and stuff. I’m still looking to find out.” (Transcript 1, page 10, lines 16-17).

Participant is determined to know more about sex reassignment surgery.

“I was trying to – I was being somebody that I wasn’t. And now that I’m a woman, I feel comfortable and I’m me... I’m serious about being a woman, you know.” (Transcript 1, page 11, lines 12-16).

Participant feels comfortable with self as a woman.

“It’s been good. It’s been a blessing. It’s been – I finally get the men that I want, you know. I can’t complain. You know I go shopping, I live my life like a regular woman, so it’s good.” (Transcript 1, page 11, lines 18-20).

Participant feels empowered and fulfilled living as a regular woman.

“Being a woman for me is being just I want to be a woman. It’s not for the men or nothing, it’s just being me and being comfortable with the person that I am inside.” (Transcript 1, page 11, lines 30-32).

Participant wants to be a woman in order to be comfortable with her inner self.

“The hormones, they really mess with you physically and emotionally, you know. So it’s like you’re taking women’s testosterones inside your body, so it’s like your body is going crazy. It’s like you have a mind frame of a man, but then once you take the hormones, like a mind frame of a woman, so it’s just like you’re fighting what you want more, the man testosterone or the female testosterone. So it’s like it’s a lot. You know. And once we take hormones, we can’t have sex, we can’t get hard no more. The peepee stays soft. Titties get bigger, but if you do come, the titties start getting smaller. So it’s like a – there’s a downfall and it’s a good thing. You know, it’s like a bad thing or a good thing. It’s a lot to do with the hormones, you know. So if you’re serious about being a woman and taking your hormones, you can’t be able to come.” (Transcript 1, page 13, lines 13-26).

Participant feels side effects of hormones are emotional and physical requiring resilience.

“The only thing that I hate about this is that we can’t have kids. Which I love kids dearly. But we could adopt some. That’s a good thing. But I really hate that we can’t have kids.” (Transcript 1, page 14, lines 12-15).

Participant thinks hormone therapy stops her from having biological kids but is fine with adoption option.

“I should have just saved one of my seeds before I came to become a woman so I could have at least a child for my mom, a grandchild.” (Transcript 1, page 14, lines 28-30).

Participant feels she should have saved own seed before transitioning.

“I just want the world to understand that transgender people, we’re still human. We have heart and we just want to be respected in this world and we want nobody to look at us different. I want everybody to see us as human beings, and we have a heart. And I want

Participant desires to be recognized/humanized and respected.

everybody to start taking us seriously.”
(Transcript 1, page 16, lines 21-25).

“Yeah, so that's been my tough challenge like trying to be accepted in like a regular work environment or a regular everyday life that I am by being judgmental and a different outlook or give me their opinion when it's not called for...Negative reactions towards how I choose to identify or live my life.”
(Transcript 2, page 2, lines 11-18).

“I think it's knowing who you are [inaudible] according to yourself, according to your identity and becoming more aware of your inner being, your inner spirit.” (Transcript 2, page 3, lines 11-13).

“It made you feel more at peace with yourself, like you're in the process of becoming 100 percent of who you are.” (Transcript 2, page 4, lines 10-11).

“My family is Hispanic and European and Black but they don't – they're more minority-based racists so it was tougher.” (Transcript 2, page 5, lines 13-15).

“So to me it's fun but it's a hard life to live.”(Transcript 2, page 6, line 21).

“So it's a hard life to live because you can't just push your opinions on people. To me I feel like you've gotta be honest and let people you date, you have to let them know off the bat so then they won't have nothing to hold against you saying they didn't have an idea or they didn't know... to me [inaudible] it's a hard life but you have to be open.”
(Transcript 2, page 6, lines 27-34).

“I've been victimized but I grew up on the streets so I can victimize back. It's just great. No, I feel like if they victimize me I victimize them back. I definitely had my fair share of people using the

Participant faces negative reactions at work and everyday life because of her identity.

Participant thinks becoming a woman is claiming one's inner being and spirit.

Participant feels more at peace with self in process of transitioning into a woman.

Participant's family is anti-transgenderism.

Transition is fun even though a hard life to live.

Participant feels authenticity trumps the difficulty of being accepted.

Participant has experienced victimization.

negative expressions towards the community upon me, like how their negative views and their negative." (Transcript 2, page 7, lines 6-10).

"And I've been luckily smart enough lately to calm myself down [inaudible] to react to [inaudible] difference being different to how they view me. So I've been trying to teach myself how to be more open to the fact that people have their own separate opinions about transitioning and trans issues than I do. And I've been very, very, very, very, very likely to remind myself that just because a girl or somebody doesn't know about trans issues, I shouldn't be mad." (Transcript 2, page 7, lines 8-15).

Trying to teach herself tolerance in the face of misunderstanding.

"I hate when guys go, I want the real vagina. Like if you're in a relationship and they're like, oh, I want a real vagina." (Transcript 2, page 7, lines 22-30).

Unhappy when not fully accepted.

"you have to be a drug addict just because you're a trans or you're a prostitute. Like I can't just walk to a store. I have to be a prostitute walking to a store. And I'm just like, why? Oh, because you're a tranny and we all know they all prostitute and use drugs. So it's just like, no, that's not true or like you have to be certain things due to the fact that you're a transition or that you're a transgender." (Transcript 2, page 7, lines 30-40).

Refutes transgender stereotypes.

"When I did it I didn't really feel any different except for when your hair and stuff grows in you get a [inaudible] and it hurts then [inaudible] that means your boobs are gonna fill out. But other than that I didn't feel any different. I had new hair [inaudible] growth and they go, oh, you get your period [inaudible] act like a bitch for like a week. And I go, that sounds like an excuse so I never had any of those issues. But if you stop doing it you get this issue of it's a weird odor that happens because it's your testosterone fighting back to push out the estrogen. So that's about the only two things I got in different from the other." (Transcript 2, page 8, lines 11-21).

Unfazed by side effects of hormones

"It makes you feel – for me it makes me feel more at peace. I just like the feminization of it, the more softness of it." (Transcript 2, page 8, lines 23-25).

Feels more at peace from feminization effects of hormones.

"I'm not sure if I plan on doing surgeries...I feel like that's saying you're playing around with God and you're changing the way he made you. I don't know if you get it." (Transcript 2, page 11, lines 18-23).

Unsure about doing sex reassignment surgery.

"I feel like it's one thing [inaudible] guys have breast plates. It's just about making them bigger or smaller with the hormones. But I feel like it's different when you go and remove things. So to me I don't feel like – I don't know if I'm gonna get surgery or not. I think I just might take hormones because hormones are supplements. So to me it's natural." (Transcript 2, page 11, lines 25-30).

Unsure about surgery but certain about choice of hormones which are natural supplements.

"I've been like this my whole life. I had no work done. It's just who I am. I don't know, I'm a male shell with a female spirit." (Transcript 3, page 4, lines 24-26).

Participant feels she's a male shell with a female spirit and has not used hormones or done surgery.

Oh, my god, the disrespect, the – I mean, it's rough. I mean, being gay is different but being trans is, oh my god, worst. (Transcript 3, page 5, lines 19-20).

Worst feeling being disrespected for being trans.

"They'll take pictures of you [inaudible] and post them on Facebook and [inaudible] – [inaudible] lose control of yourself and maybe you start doing drugs and [inaudible] commit suicide." (Transcript 3, page 6, lines 10-14).

Being ridiculed for being trans can lead the weak to drug use and suicide attempt.

"Actually, I just start hormones a month ago, and I don't know. I feel more comfortable with myself because at first, I was just a boy. Basically, the inside of me was a girl but trapped inside a boy's body, but now, I feel more of who I am because of the hormone therapy." (Transcript 4, page 2, lines 12-16).

Feeling more comfortable with self as female using hormone therapy.

“People around me, some people are supportive, and some people are just don’t like it, but it’s not up to me. It’s not for them to have me live my life. I’m gonna live my life how I wanna live it. I mean, if they don’t like the fact that I’m on hormones, then I can’t help but not pay attention to that because I don’t want people running how I live. I don’t want people disliking me because of who I am, so I just kinda say to myself, “I’m a really friendly person. If you don’t like me, then I just suggest you don’t say anything to me or don’t talk to me.” Other than that, I have love for everyone.” (Transcript 4, page 3, lines 29-39).

Recognizes her choice is unpopular but will be unbending and has nothing but love for everyone.

“A lot of real girls will be like, “That’s a boy,” and some other guys will be like, “That’s a boy,” and I just don’t pay attention to any of that. I just walk past them as if I didn’t hear what they said.” (Transcript 4, page 4, lines 13-16).

Mocked by real girls but ignores attack.

“Well, I just feel kinda a little disrespected because they don’t understand whatever that is I’m going through, and for me to be whatever I am, and for them to call me what I’m not or what I don’t prefer to be called, yeah, a little, but I just don’t let it get to me.” (Transcript 4, page 4, lines 20-24).

Feels disrespected when misunderstood but does not let it get to her.

“Yeah, I was thinking about it, but I’m not sure if I wanna get surgery or not. I think natural hormones is just what I want, no surgery.” (Transcript 4, page 4, lines 22-24).

Wants natural hormones and does not want surgery.

“it’s just hormones and the hormones that’s mixed with me being on my side of my family and just the hormones, so surgery would be like, “Dang, you put in extra work just to look like that?” I mean, I’d rather look like something from my family’s side than something that other people want me to look like.” (Transcript 4, page 6, lines 27-32).

Prefers hormones which are natural to surgery.

“I feel more better...when I finally got a chance to get my hormones, I feel more of myself because now I feel that, “Okay, well, now I have

Feeling more of self as a girl after hormone use.

titties. Now I feel more like a girl.” (Transcript 4, page 7, lines 5-10).

“I know what it feels like to grow up as a boy and also live as a girl, but it’s hard to explain it to anybody else because – well, for me, it’s just growing up being a boy knowing that I wanna be a girl, but now that I have the chance to live my life as a girl because of hormone therapy, I feel more like a girl.” (Transcript 4, page 7, lines 29-34).

Feels that she now has the chance to live life as a girl because of hormone therapy.

“Being transgender for me is just me living a lifestyle as a girl, but I know deep down inside, I was born a male, and I like that. I don’t know about anybody else, but that’s how I feel, and that’s what I know.” (Transcript 4, page 9, lines 34-37).

Being transgender is living a lifestyle as a girl.

“A lot of people think there’s a meaning to it, like, “Oh, that’s a faggot being a girl,” or, “That’s a boy being a girl.” No, it’s not that, it’s what they know – it’s a lifestyle. They know what they are when they were younger, and now that they finally got a chance to be what they want, that’s a lifestyle, not a meaning.” (Transcript 4, page 10, lines 13-17).

Being trans is a chance to live a lifestyle she desires.

“The only person that I’ve been close to is my play mother...A play mom, just someone that you call your mom that will be there for you and take care of you while you’re transforming.” (Transcript 4, page 11, lines 20-24).

Play mom plays important role in her transition.

“She’s also a transgender woman. She takes me to all my doctor’s appointments. If I have any questions, just because she’s been transforming longer than me, I just ask her, and she’ll let me know, like, “Oh, that’s fine, that’s okay.” If she don’t know, then she’ll be like, “Okay, we’ll go to the doctor and ask.” She’s just always been there for me through me transforming.” (Transcript 4, page 12, lines 5-10).

Play mom is a transgender woman who’s been transitioning longer and helpful.

“Well, I’m just like anybody else, any other human being. I feel like everyone should be treated as one and equal, and we shouldn’t have to discriminate or put anybody down. We should always help each other and bring each other up.” (Transcript 4, page 14, lines 22-25).

Desires to be accepted as human and treated justly.

“I’ve also like really become comfortable with myself to where I can live every day and go outside of LA and still be happy with myself. And so, I mean, I’m happier with my transition now. The beginning was rough and it was like something I had no clue how to make it through and I have gone through a lot of obstacles to make it to where I am now. I am still building, definitely, and getting used to it more and more.” (Transcript 5, page 3, lines 16-22).

Really become comfortable and happy with herself, following transition despite obstacles.

“We’re like a community and we love each other, but at the same time there’s a lot of hate too, but that’s – a lot of arguing with each other comes from the hate on the outside, and we don’t have anybody else to take it out on, because we’re the only ones like ourselves. That kind of becomes a struggle when I have to face other trans women who may or may not like me.” (Transcript 5, page 3, lines 29-34).

Strong community love exists despite hate from outside which is sometimes internalized and taken out against one another.

“I’ve had struggles with people yelling at me, like, you know, calling me a man or like telling me that I’m doing something wrong or telling me I’m going to get killed one day or something like that. So it’s a lot of struggles people warn you of or that you go through. But they’re gotten easier as I’ve gotten stronger and more comfortable. People leave you alone more.” (Transcript 5, page 3, lines 37-44).

Struggles with public rejection but is stronger and comfortable with herself.

“I worked at [xxx] for the last seven months, and I don’t work there now, I just quit. Just like because a lot of personal issues, like just going through emotional issues, because that’s another thing when you’re taking estrogen, your hormones and your emotions get so much harder to deal with. And some people can make them

Side effects of hormone use includes emotional issues.

go crazy, like literally crazy.” (Transcript 5, page 4, lines 27-33).

“But it gets a little overbearing sometimes. So there’s a lot of struggles, emotions, the cars, other girls, people not being okay with trans, and I don’t know, just like the ultimate element of it being hard to get a job also. Like I was lucky to get a job as a trans woman, but a lot of trans women do face like the struggle of not being accepted in the workplace, or at least not being able to be who they are or want to be in the workplace, so.” (Transcript 5, page 4, lines 35-42).

Feels heterosexism makes it hard to be the female she wants to be.

“I hate feeling uncomfortable because, I mean, it’s me, I should be able to live the way I am. But you do get uncomfortable every once in a while when they say that. It makes it hard to keep going. And that makes you really emotional sad, but I’ve kind of gotten – I mean I’ve learned to kind of ignore it.” (Transcript 5, page 5, lines 10-15).

Hates feeling uncomfortable because of homophobia but has learned to kind of ignore it.

“If I’m walking on xxx Boulevard and someone says like, “Oh, that’s a man.” Like I just learned to laugh it off now and just like – you know, it still hurts and it still makes me feel a little shitty about myself. But at the same time I know who I am and who I’m happy being. And so it’s like I can’t really let their comment get to me, because I know I won’t see them again.” (Transcript 5, page 5, lines 17-22).

Feels uncomfortable when rejected but she is unbending in claiming self and ignores detractors.

“I just got my family back in my life, and I just went and visited them actually a month ago...I saw all my friends from high school and everyone, and they all accepted me. It was the best feeling in my life. The most rewarding feeling. And so I have them as a support system.” (Transcript 5, page 5, lines 31-36).

Best feeling in life to be accepted by family and friends.

“Honestly, it means like another chance to live, really. You know, because, I mean, one thing I’m most proud of is my legal name is Chance, and so now my name is Hope now. So I was like

Feels hormone therapy is a chance to live and reclaim herself as a woman and it’s rewarding.

a Chance at the past, but now it's like my Hope for the future. And so it's like I get a chance to reclaim myself and be who I want to be. You know, you're born with a gender and with a name given to you, and you can't help what name you're given or help what gender you're given, but when you're given the opportunity, I guess, to be who you want to and like you get told that if you know you're a woman, then there's no one stopping you from being that woman that you know you are. And so to be able to go and get hormones, especially like with my insurance covering it, and to be able to live my life the way I want it and go by the name that I want to and wear the clothes that I want to and style my hair and do makeup the way I want to, it feels good. It feels really, I don't know, rewarding in some way, because I feel like in my life I know I did something, I know I reclaimed something my own, my own life." (Transcript 5, pages 6-7, lines 35-52).

"If I didn't get this opportunity, I mean, you know, I would still be living, obviously, but I could honestly say I wouldn't be living as happy. I wouldn't be living it to the fullest. Like I feel like I finally – I found my purpose. Like before I never really knew what I was going to do. I never saw my future really. I just kind of lived day-by-day, and if I didn't get to do what I'm doing now I would so be just living day-by-day and I wouldn't be happy. And I would be forcing myself to move on every day, you know, and deny myself of my true rights, you know? And I feel like now that I've been able to do what I wanted to, like I've got to accept myself. And even if other people don't accept me, like I [inaudible] myself enough to do the move and to allow myself to transition even with everyone telling me no." (Transcript 5, page 7, lines 17-29).

"You know, the first six months of my transition were probably the hardest six months of like I think in my whole life, because I was dealing with a really strong mental battle. Like, it's

Transitioning is opportunity to finally finding her purpose and accepting herself, despite rejection from some people.

Questioning phase of transition is hardest part of transitioning.

hard to explain. Like I knew it was what I wanted, but I didn't know if I had the strength to keep doing it every day. I didn't know if I had the strength to put my body through a transitional process that is almost irreversible, especially for someone who is in a home less situation like me. You know, there's no going and getting surgery through things or things like that, and so it's like the decisions I make are irreversible and so before I started estrogen, before I started actually taking it and I was transitioning just like by changing my outfits and changing the way I presented myself to people, I was just thinking like, am I doing the right thing? Would I have made it farther in my life if I hadn't transitioned?...And then, you know, I really wanted to know, will I look pretty or are things going to like happen the way I want them to happen and I was really scared. In the first six months I really was in that questioning phase, like, is this right? Am I going to do this? Am I strong enough? Can I handle what everyone's going to so say? Can I handle dealing with it for however long?" (Transcript 5, pages 7-8, lines 35-52).

"For me it's not a choice. I don't know, I can't – I don't know, like I can't go back to being like a man and ignore what I ever want to be." (Transcript 5, page 8, lines 35-37).

Going back to being a man is not a choice.

"...there's a lot of girls I know who will buy it from like Salvation Army or go buy hormones, just a shot, like go buy it from off the streets. Girls buy shit hormones off the streets all the time and just inject themselves, and they don't even know how to do it or they use the wrong needles, like a tube, because there's different types of needles." (Transcript 5, page 15, lines 1-6).

Some girls buy hormones illegally off the streets to enable them transition.

“It’s been rocky, but it’s been good...It’s just as far as me being comfortable with my skin and me figuring out where – what I’m going to do after the transition and stuff like that...Yeah, somewhat. It’s been easy, but it’s been kind of hard just – it’s really just adjusting from me being a certain way to me being a different way.” (Transcript 6, page 1, lines 27-34).

Rocky adjustment from transitioning but is now comfortable in own skin.

“Really I’ve just been dressing more like a female, wearing hair, nails, makeup. I’m not on hormones. I don’t want to be on hormones and that’s about it for right now.” (Transcript 6, page 2, lines 8-10).

Own transition ends with dressing more like a female and does not want to be on hormones.

“It makes me feel good. There’s some days I kind of belike uh, but overall I’m pretty satisfied with my decision.” (Transcript 6, page 4, lines 3-4).

Feels happy and pretty satisfied with transition decision.

“They usually expect that I’m a prostitute, but I’m not. That’s about it as far as them thinking I prostitute, but I don’t.” (Transcript 6, page 6, lines 27-28).

Rejects perception of being a prostitute.

“It’s been a hell of an experience, having to go through the trouble of finding out where to go, get your hormone therapy for free. It’s a real emotional and mental change. They start to trick your body into making it – it feels like that you think you’re pregnant, kind of. One minute, you’re fine, having fun with your friends, and the next thing you know with that same group of people that you were just having fun with, you’re depressed, and you wanna cry, and you just wanna be alone. The mood swings are a bitch to deal with.” (Transcript 7, page 2, lines 2-10).

Transitioning is emotionally and physically challenging with side effects that include mood swings.

“At first, coming out as a transgender person is awkward, I wanna say. If you think you have a lot to deal with about coming out just about being gay, it’s something completely different having to deal with coming out about being transgender because it’s not a physical thing. It’s not your body, it’s not you’re born a man and you’re trying to live as a woman, it’s you’re

Being transgender means being born a man with a woman’s mental state.

born a man, but your mental state is that of a female's. Everything you like is all girl stuff." (Transcript 7, page 2, lines 11-18).

"At the same time, it's very fun, to be honest. I love the attention that I get. I know it seems like a lot of us glorify that we see attention that we want, but it's fulfilling, it is. Not that it matters what anybody thinks about you, it just feels good to know that you're passable. You can walk on the street, and people look at you, and you get referred to as a girl everywhere you go, "Thank you, Miss. Can I take your order, ma'am? Thank you for calling, ma'am," all that, it feels good. Then, the attention from the guys is amazing, I love it." (Transcript 7, page 2, lines 27-36).

Attention and acknowledgment are amazing and fulfilling from transitioning.

"I like it. I just like it. I love the transition that I've made in my life. I love the fact that I started this, and plan on continuing on with it for the rest of my life. I finally feel comfortable in my body. I finally feel comfortable to walk outside in a pair of shorts and a tank top. It feels good to be able to walk down the street and look at your reflection in a window from a store or something, and you look and you're like, "Damn, is that me?" It just puts a smile on my face. I love it." (Transcript 7, page 3, lines 4-12).

Finally feels comfortable in her own body following transition, and loves it.

"We stick together, for the most part. We may not like each other all the time, some of us may not even speak to each other, but if I see one of them going through something like that that I went through or something similar, I'm gonna get in the middle of it and I'm gonna do what I can to stop it because nobody deserves to go through that." (Transcript 7, page 6, lines 8-13).

Trans community mostly sticking together for justice and respect.

"...my transgender mother and her husband, who I call my dad, it's a blessing just to have them in my life at all. These people have taken me into their motel rooms, or their apartments, or their houses, and let me live with them...It may not be a life for everybody to live, but the companionship and the sense of family is really

Companionship and sense of family from transgender mother helps in coping with everything.

more how I cope with everything.” (Transcript 7, page 6, lines 17-25).

“My real mother almost completely turned her back on me at that point. I didn’t have a family.” (Transcript 7, page 7, lines 2-3).

Family completely turned back on participant for being herself/a woman.

“My gay mother, my transgender mother, she’s amazing. I love her to death. She’s never let me go without, ever... my transgender mother is the one who’s been able to pick me back up and help me get back on my feet, and talk to me like a mother. She’s my mom. It’s crazy.” (Transcript 7, page 7, lines 10-22).

Trans/gay mother is amazing and supportive.

“Xxx, come on. Mother and daughter are gonna go have some dinner,” and she’ll treat me to dinner. On Mother’s Day, I actually go out and look for something to buy her on Mother’s Day. She took me in and celebrated my birthday with me last year. She’s also been a good help when it came to the hormones, the hormone therapy and everything. She’s been an amazing help as to who doctors to go to, and has gone with me to my appointments because she’s gone through it, and I don’t know exactly who to expect because I’ve never done it before. I can sit down with her and talk with her about my physical health and know that this is somebody who has gone through exactly what I’m going through now and is able to relate to me on it, and tell me, “This is what I had to do with it. We’ll talk you to the doctor, but they’re probably gonna tell you to do this. For now, just do this, and then we’ll get to the doctor. I’ll make an appointment or whatever.” Like I said, she’s been an amazing help. That’s my mom.” (Transcript 7, pages 7-8, lines 27-45).

Trans mom is loving and helpful with transition journey based on her own experience with transitioning.

“The OB/GYN that I spoke to started me on two 1.25milligrams of premarin every day, and from there, it was just a lot of sitting there and waiting, just waiting for a breast to pop out. It wasn’t anything out of the ordinary, from what I’m told. They hurt. When it’s cold outside, they get super cold. Excuse me. They’re real

Hormone use comes with physically painful feelings but worth it.

sensitive, they itch, and it's physical feelings that I don't like going through, but it's worth it, though, it really is." (Transcript 7, page 8, lines 23-29).

"Oh, I'm happy. I'm happy with it. I'm happy about the fact that I started my hormones. I'm happy with the fact that I got them, with the fact that things are there." (Transcript 7, page 9, lines 1-3).

"I guess you could say the way I've acted, the way I've portrayed myself finally fits my physical features. I feel like it's a lot easier to go ahead and be me with this body than it was before, when I was a boy. I feel like it makes some things easier." (Transcript 7, page 9, lines 7-11).

"As of right now, I don't plan on getting the surgery. I like to be different, so the way I see it, if I go ahead and get the surgery and have a doctor put that specific body part there that God put on a normal girl, then that just makes me like every other girl. I'd feel like there's nothing special about me." (Transcript 7, page 9, lines 16-20).

"The other thing I was wondering, 'Would things be easier if I was still a boy,' but then, I think about the good things that I have going for myself, like my boyfriend, and the fact that we're going back home next month. I wouldn't go back and change anything, I wouldn't." (Transcript 7, page 10, lines 6-10).

"A lot of the places, especially out here, look at the transgender girls. First thing they think of is prostitute, mess, drug addict, problem person. 'They're problem people, we don't want them here.' I would speak for myself, but I know it's not just me. For us as a collective, it's harder to go and apply for work when that's how they're looking at you, when that's how they look at you and that's how they think about you. We're low-key kinda forced to do the kinda work that we do." (Transcript 7, page 10, lines 21-28).

Happy about starting hormone therapy and its availability.

Portrayed self finally fits physical features from hormone therapy.

No surgery because participant will feel there's nothing special about her.

Wouldn't go back and change anything after transitioning.

Perceived misperceptions making it hard for trans individuals to be employed often leading to sex work.

“Basically it just means that you are matching your identity of who you are, who you feel, matching the outside to match your inner, basically.” (Transcript 8, page 1, lines 26-28).

Participant feels transitioning means matching your outside with your inner.

“Your inner is who you are. I feel female. I am female, you know what I mean? All around, I feel female.” (Transcript 8, page 1, lines 30-31).

Participants feels female from the inner.

“It’s from inside. That’s what I honestly say, because you see a lot of girls that will basically dress up, do this and that, but you have to truly feel and know who you are. If you’ve always felt this way since you were a child growing up like, “Hey, something doesn’t feel right. I know I feel like the opposite gender,” then you’ll know.” (Transcript 8, page 2, lines 3-8).

Participant feels being transgender is from the inside.

“I am on hormones. I am on hormones. Yeah, they give you hormones, they give you the spironolactone pills, which is also basically like help with the hormones. It breaks down all of your testosterone and the buildup and all of that good stuff, so muscles and everything.” (Transcript 8, page 2, lines 12-18).

Hormones breaks down all of participant’s testosterones.

“You know on the media, like Jerry Springer or something, they’ll make us look a fool. They’ll have us snatching wigs off, and it’s like they just kind of use us as something to laugh at in the media.” (Transcript 8, page 2, lines 25-27).

Participant feels media makes transgender people look a fool.

“For me, when I transitioned, like I said, I always felt who I was. I always knew who I was inside. It was never comfortable for me being around guys and other boys growing up. I was always stand-offish when I had to hang out with the other boys. I was always stand-offish, because I know who I am, and I don’t relate. I didn’t relate to nothing, basically. You know how it is, all the hyper manly. Yeah, like, okay. And I always imagined my body shaped feminine, woman. I always had that feel that my body was feminine, woman, that I am female. So that’s why I did my transition, because I knew

Participant always imagined her body shaped feminine.

who I was. I knew exactly who I was.”
(Transcript 8, pages 2-3, lines 35-45).

“It makes me feel actually very great, because I am able to live my life. Honestly, I barely started living my life since I was about 19, 18 or 19, because that’s when I came out. That’s when I first came out. And before then, I was never talking, I was just a quiet person. Quiet person, because I didn’t feel right. I wasn’t – it was hard to live life, basically, with people trying to view you and speak to you as a man, because it felt like, “Ew,” the whole time.”
(Transcript 8, page 3, lines 6-12).

Transitioning makes participant feel actually very great and able to live her life.

“I am very happy and I feel very great, because I am who I am and I speak, I talk more. I’m actually lively. I feel like I’m just coming to the world only a couple of years ago, basically, because before then I was always sectioned off and quiet. Even during my days of coming out, I still wasn’t completely who I was. So I was just getting used to it. But I’m very happy. I am very very happy that I am who I am.” (Transcript 8, page 3, lines 18-24).

Participant feels very great after transitioning because she feels she was sectioned off and alive.

“I actually feel a lot more complete. I mean, I’ve always felt who I am. Who I am inside didn’t change. It did not change, because I’ve always been the same way, just a different body on the outside. But mentally, I’ve always been the same way. And this is who I am. Everything fits now. People will address me as she, ma’am, her. It fits. It works.” (Transcript 8, page 3, lines 27-32).

Participant feels a lot more complete.

“It lets me know that, okay, at least people are finally seeing me for who I truly am. That’s what it makes me feel. When I hear that, it feels good. It does feel good.” (Transcript 8, page 3, lines 34-36).

Participant feels people are finally seeing her for who she is.

“I’m not going to lie, I have my points where I’m a little moody, but I feel like it’s just normal.”
(Transcript 8, page 6, lines 13-14).

Participant feels a little moody at times from hormone use.

“Well my name and gender is about to be changed really soon. I’m taking my papers down to the court on Thursday actually, the Thursday coming up. So I’m going to change my name and my gender, which legally my name will be who I am. So that’s my first step that I’m taking. And yeah, I’m just debating. I’m debating when it comes to another surgery, but I’m not sure if I want it or not. You know?”
(Transcript 8, page 6, lines 21-27).

Participant is unsure about surgery.

“I want for people to just start treating us like a normal person that you speak to, especially like let’s say you get on the bus. You just have a normal conversation. You can have a normal conversation with a transgender girl too.”
(Transcript 8, page 8, lines 38-41).

Participant wants to be treated like a normal person.

“For me, it means that I am able to basically just live and actually live my life and be happy. Like who I am on the outside is matching up with who I am definitely on the inside, and people feel and see that, so now they’re treating me accordingly, and it feels great, because that’s all that I’ve ever wanted to hear, and that’s all that I’ve ever felt.” (Transcript 8, page 9, lines 8-13).

Participant is able to actually live her life happily and feels treated accordingly.

“The positive part about it is you have other girls out here for you, that support you, whether they’re your friends, your sisters, even brothers out here, for me,...” (Transcript 9, pages 1-2, lines 40-43).

Participant feels supported by other trans girls.

“I can say one thing that we in the transgender community were, we’re all considered sisters. We all do look out for each other, even on a good day or a bad day, and they taught me a lot. A lot of girls that I know out here for four or five years that I’ve been out here, they’ve taught me to survive, how to live, how to love myself, and how to accept the things that come to you, whether it’s good or bad, and I love it.”
(Transcript 9, page 2, lines 31-38).

Participant considers all in the transgender community as sisters looking out for one another.

"I see myself as a girl, with or without hormones. But learning more about hormones and how it enhances you and helps you feel the girl that you completely want to be, it's a beautiful thing. I do take hormones,"
(Transcript 9, page 3, lines 6-9).

Participant sees herself as a girl with or without hormones but takes them for enhancement.

"They enhanced more like my skin, hormones, you build a core in your chest, and your core, like, it comes out to be like an actual breast, but it takes a while for it to grow completely out. And to me, it's just more for your feminine features, your skin, of course the breast enhancement and that's pretty much how much I know about it." (Transcript 9, page 3, lines 14-19).

Participant feels hormones enhance her feminine features.

"Honestly, I can say even without the hormones, I'm still the woman I am, whether they enhance my features without them or not, it doesn't take a hormone to make a woman. Inside and out is how you build your woman, because some girls say, 'Well having hair, weave, nails, makeup, and all the things, is what makes a woman,' it really doesn't. It's inside what counts. But I can say yeah, they've enhanced me a lot and I love it, and yes, I want to still continue taking hormones."
(Transcript 9, page 3, lines 28-35).

Participant feels she's a woman from inside but enjoys taking hormones.

"I'm not going to be 100% complete if I do the surgery. I'm not going to bear a child, I'm not going to feel like, I don't know if you understand. I'm kind of a mix of words, but I'm just going to say it straight forward, I'm not going to be like a biological female, no matter what..., I prefer to be different. I prefer to keep what I have, and because that's my personal opinion. Yes, I consider myself 100 percent woman. No, I don't use my front part, my private part in the front or nothing like that like some trans women do, but most don't, and that's how I leave it as." (Transcript 9, page 4, lines 6-17).

Participant won't do surgery because she won't be 100 percent complete.

"It's rocky. I barely started talking to my mom. It's not easy." (Transcript 9, page 5, line 8).

Participant barely started talking to mom.

"We don't introduce ourselves as trans women, we just introduce ourselves as women, but I have two gay mothers and I have two gay fathers and I love them to death. I love them so much. Without them, I wouldn't have learned a lot of things that I learned out here like how to take care of myself or how to be independent or how to just keep your feet on the ground. With my sisters out here as well." (Transcript 9, page 5, lines 33-39).

Participant has learned a lot of things from gay parents and trans sisters.

"when it comes to if there's problems, like if you know one particular girl out here that she's fighting somebody random, one of us, like myself, will step in and fight by her side, whether if I know her or not. I know I shouldn't be doing that, but it's the right thing to do to stand with your girls or with the LGBT community, with your family basically... Whether they're wrong or right, you still fight by your family's side, no matter what." (Transcript 9, page 6, lines 22-30).

Participant feels it's right thing to do to stand with your girls or with the LGBT community whether they're wrong or right.

"I wouldn't change anything in the world, whether I had a bad day with one of my sisters or my parent or anything like that, I wouldn't change it for the world." (Transcript 9, page 7, lines 3-5).

Participant wouldn't change anything for the world when it comes to her trans community.

"I'm not going to regret, I am a woman, so there's, what's, you know, what's to regret? You live your life as you live your life and nobody else can tell you anything about it but yourself. I don't regret making the choices that I make, whether it's being out here, whether it's being a transgender woman or woman period, I know who I am. Inside and out, I'm a woman. Inside and out I'm a woman and I will never change that. I love myself and I love the decisions that I make because I learn from them. I learn from the mistakes, the lessons." (Transcript 9, page 7, lines 20-28).

Participant feels she's a woman inside and out and does not regret decision.

Appendix C: Construction of Major Themes from Thematic Clusters

Examples of Formulated Meanings	Theme Clusters	Emergent Theme
<ul style="list-style-type: none"> Participant feels happy and comfortable living as a woman now. Participant feels good and blessed with hormone therapy as participant looks forward to becoming a woman. Participant feels comfortable with self as a woman. Hormone therapy is making participant feel more womanly. Participant feels more comfortable with self as female using hormone therapy. Participant feels more at peace from feminization effects of hormones. Participant feels more at peace with self in process of transitioning into a woman. Participant has really become comfortable and happy with herself, following transition despite obstacles. Participants feels female from the inner and out. Participant thinks that without resources to transition, she will be indescribably unhappy. Participant feels happy and pretty satisfied with transition decision. 	Feeling womanly and comfortable.	Self-fulfillment
<ul style="list-style-type: none"> Participant feels more of self as a girl after hormone use. Participant feels that she now has the chance to live life as a girl because of hormone therapy. Portrayed self finally fits physical features from hormone therapy. Participant finally feels comfortable in her own body following transition, and loves it. Participant feels hormone therapy is a chance to live and reclaim herself as a woman and it's rewarding. 	Feeling accomplished	

- Participant feels a lot more complete.
- Participant feels people are finally seeing her for who she is.
- Participant is able to actually live her life happily and feels treated accordingly.
- Transitioning makes participant feel actually very great and able to live her life.
- Participant feels very great after transitioning because she feels she was sectioned off and alive.
- Participant sees herself as a girl with or without hormones but takes them for enhancement.
- Participant feels empowered and fulfilled living as a regular woman.
- Participant feels she's a woman inside and out and does not regret decision.
- Participant wouldn't go back and change anything after transitioning.
- Participant feels that being transgender is living a lifestyle as a girl.
- Participant believes that going back to being a man is not a choice.
- Participant feels that transitioning is opportunity to finally finding her purpose and accepting herself, despite rejection from some people.
- Participant feels that becoming a woman is claiming one's inner being and spirit.
- Participant feels being trans is a chance to live a lifestyle she desires.
- Participant feels transitioning means matching your outside with your inner. Participant feels hormones enhance her feminine features.
- Participant feels being transgender is from the inside.
- Participant feels authenticity trumps the difficulty of being accepted.
- Happy about starting hormone therapy and its availability.

Feeling beautiful
and attractive

- Attention and acknowledgment are amazing and fulfilling from transitioning.
- Feeling fulfilled with transition but resolute on having a vagina through sex reassignment surgery.
- Participant feels blessed, beautiful, and attractive as a result of transition.
- Participant feels glowingly different from hormone use.

- Participant wants to be a woman in order to be comfortable with her inner self.
- Participant is dedicated about being a woman.
- Participant's desires to lead a life void of judgment is motivation for transition.
- Desire to be recognized/humanized and respected.
- Participant had difficulty being someone else.
- Participant felt she was a girl trapped in a boy's body and wanted to be female.
- Participant always imagined her body shaped feminine.
- Participant feels she's a male shell with a female spirit and has not used hormones or done surgery.
- Being transgender means being born a man with a woman's mental state.

Pre-transition
feelings

Transitioning

Commitment

- Participant put whole life on the line for transition.
- Participant is determined to become a woman and leaves family.
- Some girls buy hormones illegally off the streets to enable them transition.
- Unfazed by side effects of hormones.
- Feeling halfway accomplished until sex reassignment surgery is done.
- Determined to know more about sex reassignment surgery.
- Desires to be accepted as human and treated justly.

- Participant wants to be treated like a normal person.
 - Best feeling in life to be accepted by family and friends.
-
- Hormone therapy makes participant trip a little.
 - Participant feels a little moody at times from hormone use.
 - Side effects of hormones are emotional and physical requiring resilience.
 - Hormone use comes with physically painful feelings but worth it.
 - Transitioning is emotionally and physically challenging with side effects that include mood swings.
 - Rocky adjustment from transitioning but is now comfortable in own skin.
 - Participant thinks hormone therapy stops her from having biological kids but is fine with adoption option.
 - Hormones breaks down all of participant's testosterone.
 - Feels she should have saved own seed before transitioning.
 - Side effects of hormone use include emotional issues.
 - Transition is fun even though a hard life to live.
 - Questioning phase of transition is hardest part of transitioning.
-
- Unsure about doing sex reassignment surgery.
 - No surgery because participant will feel there's nothing special about her.
 - Unsure about surgery but certain about choice of hormones which are natural supplements.
 - Own transition ends with dressing more like a female and does not want to be on hormones.
 - Wants natural hormones and does not want surgery.

Side effects of
hormones

Doubts/Limits to
extent of transition

- Participant won't do surgery because she won't be 100 percent complete.
- Prefers hormones which are natural to surgery.
- Participant barely started talking to mom.

Post-transition victimization

- Negative reactions at work and everyday life because of her identity.
- Unhappy when not fully accepted.
- Participant feels judged and treated different for being transgender.
- Worst feeling being disrespected for being trans.
- Victimized for being herself. Made fun of for being herself.
- Participant has experienced victimization.
- Hates feeling uncomfortable because of homophobia but has learned to kind of ignore it.
- Feels heterosexism makes it hard to be the female she wants to be.
- Feels uncomfortable when rejected but she is unbending in claiming self and ignores detractors.
- Participant's family is anti-transgenderism.
- Trying to teach herself tolerance in the face of misunderstanding.
- Being ridiculed for being trans can lead the weak to drug use and suicide attempt.
- Recognizes her choice is unpopular but will be unbending and has nothing but love for everyone.
- Feels disrespected when misunderstood but does not let it get to her.
- Mocked by real girls but ignores attack.
- Participant feels media makes transgender people look a fool.
- Struggles with public rejection but is stronger and comfortable with herself.

- Perceived misperceptions making it hard for trans individuals to be employed often leading to sex work.
- Family completely turned back on participant for being herself/a woman.
- Refutes transgender stereotypes.
- Rejects perception of being a prostitute.

- Play mom plays important role in her transition.
- Play mom is a transgender woman who's been transitioning longer and helpful.
- Trans/gay mother is amazing and supportive.
- Trans mom is loving and helpful with transition journey based on her own experience with transitioning.
- Participant has learned a lot of things from gay parents and trans sisters.

Role of trans
mother

Trans
Community
Solidarity

Sense of family

- Strong community love exists despite hate from outside which is sometimes internalized and taken out against one another.
- Participant considers all in the transgender community as sisters looking out for one another.
- Participant feels it's right thing to do to stand with your girls or with the LGBT community whether they're wrong or right.
- Trans community mostly sticking together for justice and respect.
- Participant wouldn't change anything for the world when it comes to her trans community.
- Participant feels supported by other trans girls.
- Companionship and sense of family from transgender mother helps in coping with everything.

Appendix D: Final Thematic Map

First Theme: Self-Fulfillment	Second Theme: Transitioning
Feeling womanly and comfortable <ul style="list-style-type: none"> • Happy and comfortable living as a woman now • Feels good and blessed with hormone • More womanly. • Feels more comfortable with self as female • More at peace • Feels female from the inner and out • Feels happy and pretty satisfied 	Pre-transition feelings <ul style="list-style-type: none"> • Wants to be a woman • Desire for recognition and respect • Difficulty being someone else • Girl trapped in a boy's body • Imagined her body shaped feminine • Male shell with a female spirit
Feeling accomplished <ul style="list-style-type: none"> • More of self as a girl • Now has the chance to live life as a girl • Portrayed self finally fits physical features • Chance to live and reclaim herself as a woman • A lot more complete. • Able to actually live her life happily • Empowered and fulfilled • Woman inside and out and no regrets • Wouldn't go back and change anything • Living a lifestyle as a girl. • Being a man is not a choice. • Opportunity to finally finding her purpose • Claiming one's inner being and spirit. • Matching outside with inner. 	Commitment <ul style="list-style-type: none"> • Put whole life on the line • Determined to become a woman • Halfway accomplished until surgery • Determined to know more • Desires to be accepted
Feeling beautiful and attractive <ul style="list-style-type: none"> • Attention and acknowledgment are amazing • Blessed, beautiful, and attractive • Glowingly different 	Side effects of hormones <ul style="list-style-type: none"> • Trip a little. • Moody at times • Physically painful feelings • Mood swings. • Rocky adjustment • Stops biological kids • Breaks down all testosterones. • Should have saved own seed Doubts Limits to extent of transition <ul style="list-style-type: none"> • Unsure about doing surgery. • No surgery • Wants only natural hormones
	Post-transition victimization <ul style="list-style-type: none"> • Negative reactions at work and everyday life • Judged and treated different • Victimized for being herself. • Made fun of for being herself.

- Family is anti-transgenderism.
- Feels disrespected
- Mocked by real girls
- Media makes trans people look a fool.
- Perceived as prostitute.

Third Theme: Trans Community Solidarity

Role of trans mother

- Plays important role in transition of some girls.
- Trans woman who's been transitioning longer
- Supportive and helpful

Sense of family

- Strong community love exists
- Sisters looking out for one another
- Stand with your girls/LGBT community
- Sticking together for justice and respect.
- Wouldn't trade anything for community
- Supported by other trans girls.
- Companionship and sense of family

Appendix E: Institutional Review Board Approval

ENTERED
2/5/16

Institutional Review Board Project Action Summary

Action Date: February 4, 2016 *Note: Approval expires one year after this date.*

Type: ☐ New Full Review ☒ New Expedited Review ☐ Continuation Review ☐ Exempt Review
☐ Modification

Action: ☒ Approved ☐ Approved Pending Modification ☐ Not Approved

Project Number: 2016-02-120

Researcher(s): Marcel Fomotar Doc SON
Dr. Jane Georges Fac SON

Project Title: Exploring the Lived Experience of Male-to-Female Transgender Youth Accessing Trans-Related Healthcare in Los Angeles

Note: We send IRB correspondence regarding student research to the faculty advisor, who bears the ultimate responsibility for the conduct of the research. We request that the faculty advisor share this correspondence with the student researcher.

Modifications Required or Reasons for Non-Approval

None

The next deadline for submitting project proposals to the Provost's Office for full review is N/A. You may submit a project proposal for expedited review at any time.

Dr. Thomas R. Herrinton
Administrator, Institutional Review Board
University of San Diego
herrinton@san Diego.edu
5998 Alcalá Park
San Diego, California 92110-2492

Office of the Executive Vice President and Provost
Hughes Administration Center, Room 214
5998 Alcalá Park, San Diego, CA 92110-2492
Phone (619) 260-4553 • Fax (619) 260-2210 • www.sandiego.edu