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Tristan Karel Martin  
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## **ABSTRACT**

Literature that addresses sexual issues pertaining to sexual satisfaction is often not inclusive and neglects transgender, specifically trans masculine, identities. The media frequently highlights physical transitions but ignores the distressing psychological effects of dysphoria on sexual satisfaction and the influence of sexual partners during sex. In this quantitative study informed by a systemic gender affirmative lens, trans masculine adults (N=1,041) responded to a questionnaire on their experiences of transgender congruence, sexual satisfaction, and affirmative sexual partners. Data analyses revealed diverse participant and partner demographics. The transgender congruence variable expressed group differences based on gender/sexual identity, age, and medical transition. An affirmative sexual partner increased sexual satisfaction through aspects of safety, connection, attraction, support, feedback, and communication. Affirmative sexual partners moderated the experience of transgender congruence and sexual satisfaction for the trans masculine participants. In conclusion, sexual partners can positively impact sexuality by providing affirmation that increases sexual satisfaction for trans masculine people as they experience varying degrees of transgender congruence.

TRANSGENDER CONGRUENCE AND SEXUAL SATISFACTION IN TRANS  
MASCULINE ADULTS: THE ROLE OF AFFIRMATIVE SEXUAL PARTNERS

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Dissertation  
Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in  
Marriage and Family Therapy

Syracuse University  
May 2020

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## Acknowledgements

I would like to express my deepest appreciation to my dissertation committee - Drs. Deb Coolhart, Rashmi Gangamma, Dyane Watson, Linda Stone Fish, Melissa Luke, and Rob Pusch. I am thankful for your willingness to participate and your commitment to social justice for the LGBTQ community.

I am deeply indebted to my advisor, Dr. Deb Coolhart, a respectable clinician and professor. I'll never forget stumbling across your research in my master's program, it was then that a light went off and you inspired my future aspirations to work with the trans community. Throughout the past few years you not only guided me academically, but supported growth and self-acceptance in many areas of my life. I thank you for your support of my own research ideas and confidence in my abilities. My experience as your advisee was intellectually challenging, but truly exciting and fun. I look forward to our future collaboration.

Dr. Rashmi Gangamma, thank you for unleashing my inner statistic beast. Your passion for research is contagious. I thank you for your patience and encouragement throughout this process that ultimately strengthened the final project.

Dr. Dyane Watson, thank you for being the "calm in the storm" your warming presence has helped guide many of us through academic and clinical hurdles. I will always be grateful for all the moments you expressed your care and concern by just checking in.

Dr. Linda Stone Fish, you have created an academic space that facilitates growth and produces outstanding academics and clinicians. I am thankful for your leadership and meaningful comments throughout the years that have strengthened my professional and personal life.

Mom and Dad, thank you for being a constant source of love and security. You have encouraged and helped me at every stage of my personal and academic life and longed to see this achievement come true. I am thankful for your calm presence and every word and gesture of love that has influenced where I am today. Throughout my life you attended approximately 450 basketball games and since then have remained my biggest cheerleaders. We have made many transitions as a family system and I am appreciative of your evolving support.

My heartfelt thanks to Jenny, my partner in crime. Thank you for your friendship, your humor, kindness, and caring nature are truly special. Witnessing your stance as an ally has changed my worldview and I respect and admire that passion. You have opened my mind to new experiences and heart to moments of understanding deeper meanings. I can't express my gratitude enough for your continuous love and support.

To my chosen family, thank you for the support throughout my journey.

## Dedication

To Kathryn, I thank you for finding the strength and courage to continue. I recall many moments that defeat was knocking at your door. The unforgiving world made your youth a physical and mental struggle as you stumbled to find meaning. Thank you for not giving up and for pushing through to find yourself and be the man you were destined to be. You opened a new door into a world that offered support and love to forever transform your journey.

To all the participants that lived a prior life, it is my hope that you find the strength and courage to continue. Thank you for inviting me into your lives to explore a part of your journey. I am grateful for your time, willingness, and effort to share your experiences. You are not alone, and you are valid.

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## **Chapter One: Introduction**

My trans sexuality is the mental and physical pleasure existing in the same space. It's a fragile world, constructed on beliefs and acceptance, and mirrored in a partner's gaze. This is not to say that it is all a mind game: that undercuts the fact that the connection between partners is visceral and real. Our worlds are connected at some place that reaches beneath the surface... (Van, 2004)

### **The Need for Trans Masculine Inclusion**

Literature focusing on the transgender population has increased in recent years within therapeutic fields. Clinicians note that past literature that addressed sexual issues often neglected or pathologized the transgender population (Lev, 2004). Despite greater inclusion, literature addressing sexual needs and issues beyond medical transition remains underreported (Doorduyn & Van Verlo, 2014; Iantaffi & Benson, 2018). It is important to note that a transgender identity directly influences aspects of sexual experiences and sexual satisfaction (Nikkelen & Kreukels, 2018). Literature has yet to address the depth of transgender sexual experiences in relation to body dysphoria and varying degrees of transgender congruence, meaning the sense that one's body aligns with their gender identity (Galupo, Henise, & Mercer, 2016). A review of sexual health literature by Stephenson et al. (2017) revealed that literature on the sexual health of trans masculine people remains limited with a wide array of research possibilities yet to be explored. Transgender people often face additional challenges related to their sexual experience such as sexual behavior and sexual satisfaction (Nikkelen & Kreukels, 2018). Since a transgender identity closely relates to sexual identity and body image, trans people may struggle sexually. Therefore, previous research has failed to address the impact of low transgender congruence on sexual satisfaction, and the role of affirmative sexual partners for trans masculine people.



The presence of clients with diverse and marginalized gender identities is growing in clinical spaces. Although previous studies addressed sexual issues in lesbian, gay, and bisexual populations, they neglected to include transgender, specifically trans masculine samples (Frost & Meyer, 2009; Gil, 2007). Authors note that both the media and research often focus on physical transition and surgical interventions, ignoring the psychological experiences that transgender people experience (Lev & Sennott, 2012; Nikkelen & Kreukels, 2018). The understanding of this psychological experience is critical for trans masculine people, considering the costs and complications that present a barrier to obtaining gender confirmation surgery (GCS) (Rachlin, Hansbury, & Pardio, 2010). Additionally, society's standards of masculinity may amplify dysphoria and dissatisfaction with the body leading to low transgender congruence (Green, 2005), influencing sexual satisfaction (Velez, Breslow, Brewster, Cox, & Foster, 2016). It is important to address this in order to normalize all bodies and issues related to being trans masculine, since dysphoria is often a prominent experience of a transgender identity, making it difficult for some to have satisfactory sexual experiences (Platt & Bolland, 2018).

Previous research suggests that clinicians assumed trans people were asexual, hated their body parts, or needed to cease sexual acts in order to transition (Iantaffi & Benson, 2018). However, current clinical literature and research implies that trans people experience active sex lives and use their bodies both before and after social and/or medical transition (Brown, 2010; Lev, 2004; Ki, Hoebeke, Heylens, Rubens, & De Cuypere, 2008). It is important that clinicians recognize this shift in the conceptualization of trans sexuality, remain knowledgeable, and affirm all trans identities and sexualities. If clinicians are able to normalize these experiences, trans people may develop resiliency that increases hope, leading to positive mental health outcomes.

## History

In comparison to previous literature, current literature depicts trans identities more positively and with a sense of normalcy. It is essential to provide the history of trans identities in order to highlight shifts in resiliency and specifically the shift in discussions for this population. Gender transitions are noted in historical literature as far back as 1503 B.C. throughout ancient Egypt, Greece, and Rome (Campanile, Carlà-Uhink, & Facella, 2017). One of the earliest documented gender transitions took place during the reign of Emperor Nero, after the death of his wife in 65 A.D. A male servant who resembled his deceased wife transitioned to a woman and married Emperor Nero (Benjamin, 1966). Further, within the 16<sup>th</sup> to 18<sup>th</sup> century, as early as 1577, there were reported accounts of transgender individuals within French literature (De Savitsch, 1958). During this time, many assigned male at birth Native American tribal members, such as the Mohave and Pueblo tribes, performed stereotypical tribal women's tasks and lived as women (Devereux, 1937). Benjamin (1966) also highlighted early accounts of transgender men within ancient Mediterranean, Indian, Oceanic, and African tribes who dressed in masculine attire, adopted masculine mannerisms, and during sex strapped "a gastrocnemius from the leg of a reindeer, fastened it to a broad leather belt, and used it in the way of masculine private parts" (p.101).

As a primary source, Harry Benjamin (1966) provided a succinct background on transgender identities. It is important to highlight the origin of terminology and provide a historical timeline of medical and mental health origins of working with this population. To begin with, Magnus Hirschfeld, a Sexologist practicing in Germany, coined the term transvestism in 1910, in his book, *Die Transvestiten*, which was later translated in 1991 to *Transvestites: The Erotic Drive to Cross-Dress* (Benjamin, 1966; Hirschfeld, 1910, trans 1991),

which contained biographies of people we would label today as transgender. Hirschfeld is credited as the first person to use the word transsexual in his article titled *Die Intersexuelle Konstitution*, translated to “The Intersexual Constitution” in which he mentioned the term “seelischer transsexualism” translated to psychic transsexualism (Hirschfeld, 1923).” Tragically, Hirschfeld’s Institute for Sexual Science was a target following Nazi rise to power in Germany and a majority of his library was destroyed (Benjamin, 1966). A few years later in 1930, under the supervision of Hirschfeld, Lili Elbe became the first documented person in the 20<sup>th</sup> century to undergo gender confirmation surgery; her story has gained recent attention in the movie *The Danish Girl* (Hooper et al., 2016).

Moving forward, David O. Cauldwell, was the first American Sexologist to use the word *transsexual* in medical literature (Ekins & King, 2001). Within his article, *Psychopathia Transsexualis* in *Sexology* magazine, Cauldwell defined transsexual as “individuals who wish to be members of the sex to which they do not properly belong” (Cauldwell, 1949, p. 275). Within his article he attempted to find the root of etiology, overtly pathologizing these individuals as psychologically ill and unhealthy, therefore a ‘psychopathia transsexual.’ Later in 1949, he published his autobiography, *The Diary of a Sexologist* (Cauldwell, 1949b). In his autobiography, which included letters from trans people, he mentioned the term *transsexual* to refer to those who wished they were members of the other sex and desire surgery to alter their physical characteristics. Cauldwell labeled the transsexual as one who was a transvestite, with the desire to wear clothing of the other gender and having transsexualism, which demonstrated unhealthy patterns. Despite his field of study and labeling himself a scientific pioneer in this area of research, there is little evidence that Cauldwell worked with trans people; in fact, it is noted that he only received letters from trans people (Ekins & King, 2006). His autobiography

revealed that he deemed “sex change” unethical and believed that a person could never be a member of the opposite sex.

The most prominent and well documented affirmative figure in early transgender studies is Harry Benjamin, an endocrinologist who was born and trained in Germany (Meyerowitz, 1988). Benjamin frequently met with Hirschfeld at his institute in the 1920s to discuss their findings and collaborate on future research (Benjamin, 1966; Ekins & King, 2001). After moving to the United States in 1953, Benjamin gave a lecture at the New York Academy of Medicine in which he referenced Cauldwell’s article. He later published *Transvestism and Transsexualism* in the *International Journal of Sexology* (Benjamin, 1953). In his original book, *The Transsexual Phenomenon* (1966), Harry Benjamin provided a distinct definition of transsexual, one who is unhappy and has a desire to change their sex. He added that distress can be relieved by socially, medically, and legally transitioning. He stated that these individuals are unhappy with their anatomy, specifically their genitals, and feel disgust along with an intense desire to live outwardly as the opposite sex (Benjamin, 1966). Benjamin discussed the personal, in-depth tragedy of living with a transgender identity, which consisted of self-mutilation, suicide, rejection, drugs, alcohol, and a life wrapped in sadness that only transition can cure.

Benjamin highlighted that the physical and psychological clash created a body and mind not in sync. With his roots in psychiatry, Benjamin notes that there is relief for the transsexual through *dressing* and/or social and medical transition (Benjamin, 1966). While using language that is outdated today, yet still applicable to the transgender community today, Benjamin said that the transsexual has a longing and desire for a “sex change” in order to be complete. Benjamin was considered an ally and a very well respected pioneer within his field, receiving admiration from the trans community. However, many physicians during his time were not very

well educated in working with these patients and considered them mentally ill and prescribed institutionalism (Benjamin, 1966). In 1979, Benjamin formed the International Gender Dysphoria Association, now known as the World Professional Association for Transgender Health (WPATH), which provided clinical guidelines or Standards of Care (SOC) for medical and mental health professionals in working with transgender patients. His work profoundly impacted the mental health field as he stated:

Psychotherapy with the aim of curing transsexualism, so that the patient will accept himself as a man, it must be repeated here, is a useless undertaking with present available methods...the mind of the transsexual cannot be adjusted to the body, it is logical and justifiable to attempt the opposite, to adjust the body to the mind (Benjamin, 1966, p.53).

**Trans masculine sexuality.** In *The Transsexual Phenomenon*, Benjamin discusses the *female transsexual's* (i.e., transgender man) sex life, stating that “Sexually, female transsexuals can be ardent lovers, wooing their women as men do, but not as lesbians...They long for a penis, yet mostly understand realistically that the plastic operation of creating a useful organ would be a complicated, difficult, highly uncertain, and most expensive procedure” (Benjamin, 1966, p.85). His depiction of these individuals separates sexual identity from gender identity and highlights the dysphoria produced by complications from GCS. Additionally, he addressed the variation of sexuality and the first documented attempt to describe sexual relations for transgender men:

The technique of sex relations naturally varies greatly. Petting and kissing are followed by some form of genital caressing. Mutual masturbation by manual stimulation is probably as frequent as oral-genital contact. Most desired and perhaps most frequently practiced is the face-to-face position of an imitation of the heterosexual coitus, the transsexual female [trans man] on top, rubbing the clitoris against the partner's genital

region. This is accomplished by the TS's closed legs between those of the girl, which are spread apart, or by intertwining the legs, known as "dyking " (Benjamin, 1966, p. 86).

Benjamin provides autobiographies of transgender people in *The Transsexual Phenomenon*, most applicable is the "Autobiography of a female transsexual [trans man]" by Joe (Benjamin, 1966, p. 128). In his account, Joe describes his struggles and deep longing for a penis, which often resulted in fantasizing sexual satisfaction through intercourse with a woman.

### **Terminology**

A majority of the early literature from Cauldwell to Benjamin focused on transgender women. Benjamin (1966) insisted that this was because the first documented GCS case, Christine Jorgensen, was a transgender woman. Meyerowitz (1998) theorized that only a minority of transgender men were able to access medical transition due to gender inequality and having less access to financial means. Additionally, the language used by early pioneers was not congruent with today's lexicon as *female transsexualism* (Benjamin, 1966) was used to describe those who were assigned a female sex at birth, and identified as, or later transitioned to men. Therefore, it is essential to establish current definitions of terminology used in this document, while keeping in mind that language has multiple meanings and is continuously evolving. For mental health professionals, it is important to retain accurate and current terminology concerning trans issues, gender identities, and transition options (Iantaffi & Benson, 2018). Medical professionals through a combination of hormones, chromosomes, biology, and most commonly genitalia (Sanz, 2017) assign a *sex* at birth. Amidst her media fame, Jorgenson and many other pioneers in the community began using *transgender* instead of transsexual after it was printed at a trans conference in 1974 (Sylvia, 2015). The most current definition of transgender (*or trans*) is a person whose gender identity differs from their sex assigned at birth (Hendricks & Testa,

2012). *Gender identity* is a personal experience of gender through psychological experiences, identity, presentations, and roles (Buck, 2016). *Gender transition* is the process of aligning physical secondary and/or primary sex characteristics with the internal or psychological gender (Thurston & Allan, 2018).

As the term transgender has readily been discussed thus far, it is important to give language to those who do not identify as transgender. Although, *non-transgender* can be used, *cisgender* is a more applicable term, which has frequently been used in academic spaces. The word cisgender was first published by Volkmar Sigusch, a German Sexologist in his 1991 article “Die Transsexuellen und unser nosomorpher Blick” translated to “Transsexuals and Our Nosomorphic View.” Sigusch used the word “cis” to describe those who were comfortable with both their assigned sex and gender identity (Sigusch, 1991). A few years later, between 1994 and 1995, the word began appearing in academic and transgender forums by biologist Dana Leland Defosse and a transgender man, Carl Buijss. More recently, the American writer and trans woman Julia Serano, used the term cisgender in her book *Whipping Girl* (Cava, 2016; Serano, 2016). Current scholars define a cisgender or non-transgender person as one who agrees and identifies with their sex assigned at birth, experiencing a parallel gender identity (Iantaffi & Benson, 2018).

This lack of congruency for transgender people often creates a strong psychological and physical experience of distress called *gender dysphoria*. The evolution of this term began with the introduction of *Gender Dysphoria Syndrome* by Norman Fisk in 1973 (Sylvia, 2015). As the media began publicizing Jorgenson’s experience, a common understanding developed that a transsexual gender identity included feelings of gender dysphoria. Fisk readily quoted Benjamin, stating that he witnessed gender dysphoria in his patients (Fisk, 1974). This was mimicked in

Jorgenson's experience, developing the "wrong body narrative" as she described being a woman in a man's body (Ekins & King, 2005).

In the early 1980's, *transsexualism* became an official disorder in the American Psychological Association's Diagnostic and Statistical Manual of Mental Disorders, (DSM-III) and was then changed to *gender identity disorder* in the DSM-IV (Lev, 2006). Both of these definitions were treated as disorders rather than an experience of being transgender. Finally, in 2013, the DSM-V shifted to using *gender dysphoria* which focused on the condition and experience rather than treating the identity as a pathology (American Psychiatric Association, 2013). Although commonly referred to as gender dysphoria, many trans people are not dysphoric about their gender, rather their body. In other words, many trans people are very comfortable and clear about their gender; rather, it is the incongruence of their physical body causing the feeling of dysphoria. Therefore, *body dysphoria* will be the term used in this document to describe the distress caused by a lack of anatomical congruence or the mismatch between assigned sex and gender identity (Lev, 2004). *Transgender congruence* will be used to discuss the varying degrees of appearance congruence and gender identity acceptance, with higher transgender congruence equaling lower body dysphoria.

Gender can encompass many different identities expressed inwardly and outwardly including masculinity, femininity, neither, or both. In previous studies, authors used terminology such as FTM (female-to-male), implying a binary gender, and not allowing for flexibility, or transgender/trans men. This study will use the term *trans masculine* to describe the population, remaining inclusive of all identities and expressions. This term includes people assigned female at birth (AFAB) who identify as either *binary* (e.g., FTM, male/man, trans man/male, etc.) or *non-binary* (e.g., agender, demi guy, genderqueer, etc.), falling on a masculine spectrum. *Sexual*



*identity* is the variety of expressions, roles, or genders that a person finds a sexual attraction to in relation to their gender identity (Iantaffi & Benson, 2018). Trans masculine people have diverse sexual identities that intersect with their gender identity such as bisexual, gay, queer, pansexual, straight, or asexual (dickey, Burnes, & Singh, 2012).

### **Intersectionality**

The idea of intersectionality has permeated the social sciences literature as of late. Specifically, from a therapeutic aspect, I believe that outcomes of therapy cannot be successful without remaining intersectional. Intersectionality is a term often credited to Kimberlé Crenshaw, a sociologist and law professor, first used in “Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics (Crenshaw, 1989).” Here, Crenshaw centered Black women, examining their experience of both race and gender. Instead of creating a mutually exclusive discussion, Crenshaw took an intersectional approach, examining the two together, broadening feminism and preventing erasure of either identity (Crenshaw, 2018). Further, she acknowledged that by focusing on privileged groups, the complexity of gender and race are ignored. Therefore, “The intersectional experience is greater than the sum of racism and sexism...” (Crenshaw, 2018, p.140). This term has vibrated throughout marginalized populations, allowing a lens in which the totality of identities can be explored.

**Trans masculine intersectionality.** According to Nagoshi and Brzuzy (2010), transgender people experience the self as holding multiple identities that constantly intersect with socially constructed aspects of identity. Therefore, in addition to all the identities discussed below, trans people experience discrimination from the broader society regarding how they should enact their different identities. Trans people are continuously fighting in a world in which

“Gender is traditionally assumed to be based on a binary, mandatory system that attributes social characteristics to sexed anatomy” (Nagoshi & Brzuzy, 2010, p. 433). Bowleg (2013) summed up intersectionality brilliantly, “Once you’ve blended the cake, you can’t take the parts back to the main ingredients” (p. 754).

The trans community often experiences discrimination through micro and macro levels. For example, at the macro level, transgender people are discriminated against at both the federal and state level. Although laws are rapidly changing in both directions, it remains firm that four U.S states (i.e., Ohio, Idaho, Tennessee, and Kansas) do not allow an individual to change their gender marker on their birth certificate (Transgender Law Center, 2019). Another important facet of transition that is often overlooked is the never-ending paper trail of those who legally transition, they cannot erase their gender history. For someone assigned female at birth who changes their gender marker to male on their birth certificate, driver’s license, and even social security, they can never erase their previous gender identity. For example, whenever their social security number is run at a doctor’s office, school, or a background check is conducted for a lease or a potential employer, their previous name and gender will show up, which can lead to potential ramifications. At the micro level, transgender people may experience discrimination from superiors, coworkers, families, or friends. In addition, transgender people rely on the medical community and therapists for access to medical transition (Coolhart, Baker, Farmer, Malaney, & Shipman, 2013). These examples give a glimpse into the complexity of gender transition and the hardships that trans people may experience.

By applying an intersectional lens to the trans community, the previously mentioned legal ramifications are considered with the identities of each person. In other words, the intersection of identities interacts with power. Those in privileged spaces that hold power, create additional

discrimination and marginalization (Cho, Crenshaw, & McCall, 2013). Identities that trans masculine people hold continuously interact, such as race, ethnicity, religion, sexual identity, education, socioeconomic status, and ability. This idea of intersectionality combines individual identities with larger systemic, societal, and historical ideals.

Specifically, in regard to the transgender community, intersectionality can be applied creating triple, or even more identities that experience discrimination. Transgender people often experience discrimination based on their gender identity (Galupo & Orphanidys, 2018). Additionally, discrimination may also be based on race, class, ethnicity, or other aspects of identity. For example, consider an individual who identifies as a trans man, person of color, has a disability, and is of low SES. These four identities create four different experiences that blend into his perceived interactions with self and other. Through gender, race, ability, and SES, he is navigating the world constantly aware of his identities. In other words, by adhering to an intersectional lens, identities are mutually influencing one another, and all identities must be considered. In sum, “The intersections of oppressed components of identity, known as intersectionality, capture the unique detrimental experiences of minorities as well as the ways in which marginalized populations exhibit resistance and resilience” (Galupo & Orphanidys, 2018, p.113).

**Gender intersectionality.** Within this study, the sample highlighted multiple intersections of identities for both the participants and their sexual partners. The demographic survey highlighted gender identity, sexual identity, age, race/ethnicity, social economic status, and medical transition. Gender itself is an identity that can be unpacked within a trans masculine identity. The process of transitioning from female to male, although expected to receive privilege, often does not. For example, the long history of advancement in gender confirmation

surgeries of transgender women exemplifies power and money, specifically for those identified male at birth, white, and middle age, had greater ability to transition by travelling to foreign countries (i.e., Germany) and paying for expensive surgeries (Rubin, 2003). Therefore, the more transgender women who transitioned that could afford it, the more advanced the surgical techniques became. In addition, before the second wave of feminism of the 1960s swept the U.S., women were predominantly restricted in their expression of gender identity due to legal obstacles and the overall suffrage of their gender (Butler, 2006). With this being said, I believe those who were assigned female at birth but expressed a masculine gender identity may have not had the space or voice to transition publicly, or the privilege to transition.

The current study included both non-binary and binary trans masculine participants. There is a separation between those identities which may result in encountering discrimination within the community or in broader social contexts. For example, tension within the trans masculine community exists over “muscular, straight, cis-passing, white men” being the face of the community. This inaccurate representation may increase tension and divide the community. Those identifying as non-binary trans masculine may not feel validated by not upholding these standards and may have a more complicated medical transition, since there is an assumption that medical transition is tied to the binary.

**Sexual identity.** Since gender and sexual identities are two distinct entities, the intersection of sexual identity impacts an individual’s experience of privilege and discrimination. Historically, trans masculine people were assumed straight and the understanding and representation of other sexual identities were slim (Edelman & Zimman, 2014). Currently, many clinicians have noted many identify as gay post transition (Rowniak & Chesla, 2013). The sample in the current study found diverse sexual identities such as straight, gay, queer, bisexual,

or pansexual. This intersection of a trans person assigned female at birth (AFAB) who is attracted to men, further creates stigma and discrimination of a gay identity. They may also encounter discrimination from professionals, specifically the medical community, from this identity intersection.

**Age.** Next, age could impact the experience of a trans masculine identity. For those who were assigned female at birth and transitioned post-puberty, they experienced a female puberty that resulted in the widening of hips, breast development, menstrual cycle, feminine facial structure, and other feminine features. This experience of puberty not only can create extreme dysphoria, but also irreversible changes that can impact self-esteem and view of self as a trans masculine person. However, for those who were able to medically transition before puberty, hormone blockers restricted the development of these secondary sex characteristics (Ehrensaft, Keo-Meier, & Yuen, 2019).

Another intersection of age is the timeline of testosterone, as someone who transitions in their 40s, 50s, 60s, or even 70s, the effects of testosterone will not be as strong since the body has been running for years on estrogen. Additionally, if an older trans masculine person seeks gender confirmation surgery, it is possible that they will have more complications since the body has aged. Finally, another interesting aspect of age, as shown in Martin and Coolhart's study (2019), the older trans masculine people who were interviewed expressed less dysphoria about their lower parts, versus those of younger generations. As one participant explained his transition and the experience of living in his body for so long, he was satisfied with the effects of testosterone and did not desire lower surgery.

**Race and ethnicity.** Considering the history of racial discrimination in the United States and the continuous fight for equal rights, those who identify as transgender and a person of color

(POC) have an ongoing fight around both their gender identity and race/ethnicity (Phillips & Stewart, 2008). Although previous studies have often failed to exclusively address transgender intersections, studies have explored the intersection of race and sexual identity (Bowleg 2008; 2013). Bowleg (2008) explored the intersectionality of Black lesbian women in research. She highlighted that identities have to be interdependent in order to gather high quality research; mutually exclusive identities can create further social inequality. Bowleg (2013) also explored experiences of intersectional identities for gay and bisexual men. The findings discussed experiences of POC in LGB spaces, which included the juggling of identities (to be Black, a man, or gay, first). This internal experience could also be applicable to trans masculine people. For example, one may experience negative stereotypes for being a Black man, encounter racial microaggressions within white LGBT communities, transphobia in Black communities, and/or heavy gender roles and expectations to act masculine (Riley Snorton, 2017). Another example taken from qualitative interviews from Martin and Coolhart's (2019) study on sexual satisfaction in trans masculine participants, was the low representation of POC in products to relieve dysphoria, such as prosthetics and postoperative results. In other words, skin colors of prosthetics are commonly made for white trans masculine people and may not represent accurate coloring when utilized by POC. In addition, the medical community is not properly trained in addressing postoperative care for keloids, a skin condition which more commonly affects POC, as Dozier (2005) gave one participant's account of not even considering chest surgery because of keloids.

**Socioeconomic status.** Another intersectional identity heavily considered in this study was socioeconomic status and/or class in regard to accessibility to medical transition. In the current study, demographic questions were asked about obtaining hormone therapy and GCS. It

is important to acknowledge that not every trans masculine person has access to medical transition. Although insurance companies in most states now cover hormones and GCS, there are additional financial barriers such as postoperative care, travel, deductibles, supplies, and complications that trans masculine people may have to pay for out of pocket. Medical transition itself becomes an identity within the transgender community, comparing those who have or have not had surgery, creating further marginalization or privilege within their own community. In social media groups, those who have had GCS are often idolized and praised for “completed” transition. It is important to note that a trans masculine person who is not on hormones or has not had GCS is still valid in their gender identity.

**Sexual partners.** The final intersection considered within this study was the sexual partner. As a trans masculine person enters a serious or casual relationship, either open, monogamous, or polyamorous, the partners’ identities intersect within the relationship. Since a sexual experience can often be a partnered activity, trans masculine people may have different sexual histories. For example, one individual may not be out about their identity to partners initially or might have difficulty finding a partner because of their gender identity. The intersection of partners’ identities transcends throughout the sexual relationship. It is important to consider the partners’ race, class, gender identities, and sexual identities in order to conceptualize the experience of the sexual relationship.

Martin and Coolhart (2019) explored sexual satisfaction in trans masculine people who were sexually active in the past or present. From the themes generated, a subtheme that stemmed from the relational theme was the partner’s identity. Participants described dating gay cis men, gay trans men, bisexual cisgender women, and heterosexual cisgender women. These partner sexual identities influenced dysphoria by either reducing or increasing it in relation to the

partner's sexual identity. The authors found that sexual experiences with affirming sexual partners and language decreased the level of dysphoria (Martin & Coolhart, 2019). Within relationships, partners' identities continuously interact and overlap (Addison & Coolhart, 2015) creating a deeper understanding of relational intersectionality.

Trans masculine people may turn to their partner for comfort and security. A secure attachment and understanding of gender identity increase the ability to view their gender identity more positively (Amodeo et al., 2015). This secure attachment is created through shared identities and conversations around ways their identities intersect. Considering this aspect of resiliency, partners and those connected to trans masculine communities can create a sense of unity around their identities. This sense of community, or collective action against oppression, creates bonding, and belonging among the group (Addison & Coolhart, 2015).

## **Transition**

Documented research on gender confirmation surgery (GCS) began in 1910 when Eugen Steinach, a physiologist in Vienna, conducted surgical experiments on rats and guinea pigs (Meyerowitz, 1998). His work later influenced Hirschfeld, as he became the pioneer of GCS at the Institute for Sexual Science, supervising patients such as Lili Elbe in 1913, the first publicized transgender woman. Additionally, the first trans man to undergo hysterectomy and gonadectomy in the United States was Alan L. Hart in 1917 (Hart, 1935). Historically, medical transition received attention between 1940-1950 when Cauldwell and Benjamin began publicly speaking the word transsexual. Christine Jorgenson drew media attention as she traveled to Denmark, becoming the first documented transgender woman to undergo gender confirmation surgery. However, within the United States, many hospital boards consisted of priests and ministers who blocked GCS (Benjamin, 1966). Finally, the United States began publicly



advertising GCS at The John Hopkins Gender Clinic in the 1960s with Benjamin behind the movement (Meyerowitz, 1998). In *The Transsexual Phenomenon*, Benjamin (1966) described transition options for transgender men, stating that relief is found in medical transition through androgen treatment with the possibility of GCS in the future and warned providers, “If he insists on psychotherapy instead, he may do more harm than good” (p.88).

Gender transition is the process of physical and aesthetic change to appear outwardly as one’s internal gender identity. It is important to note that not all trans masculine people desire or pursue medical transition. Gender transition may include social, psychological, legal transition, hormone therapy, and gender affirming surgery. Trans masculine people may wish to obtain congruence and lessen body dysphoria through social and/or medical transition (Hendricks & Testa, 2012). Social transition may include dressing in masculine clothing, having a masculine haircut, and asking others to use affirming pronouns and a chosen name. It may also include legal name and gender marker changes on driver’s license, social security, birth certificate, passport, bank, and/or other medical/legal documents. Medical transition for this population may include hormone therapy with testosterone and/or surgeries such as chest reconstruction (i.e., top surgery), hysterectomy, metoidioplasty, and/or phalloplasty (Aydin et al., 2016). Medical transition often improves sexuality as trans masculine people may feel more confident and experience less dysphoria. Williams, Weinberg, and Rosenberger (2013) described the sexualized embodiment that ensues from testosterone and top surgery.

For trans masculine people, systemic, societal factors, and barriers to lower GCS can amplify body dysphoria. Although lower gender confirming surgeries are highly successful and result in high aesthetic and performance outcomes, trans masculine people may not have the knowledge or be mentally prepared for the long journey that often takes up to two years for

healing and surgical stages. GCS for trans masculine people is often not accessible due to the fear of complications from urethral lengthening and exceedingly high financial obligations required, as not all insurance companies cover certain procedures and money is needed for travel, after care, and time off from work (Rachlin et al., 2010). In addition to surgical barriers, this population may experience body image distress through toxic masculinity and muscularity perpetuated by cisgender men in the media (Armstrong, 2006). Throughout physical transition, trans masculine people may experience shifts in sexual performance, sexuality, or sexual acts. Yet, sexual issues literature lacks a deeper understanding of the complexities of trans masculine sexuality and sexual identity in relation to transgender congruence. Literature, which will be discussed later, has broadly addressed these experiences of body dysphoria and body image in trans masculine samples (Pfeffer, 2008; Schilt & Windsor, 2014; van de Grift et al., 2016; Velez et al., 2016). However, these studies do not address the influence of transgender congruence on sexual satisfaction and the role of affirmative sexual partners.

## **Theoretical Framework**

### **General Systems Theory**

It is important to address this topic from a relational lens, examining the role of the sexual partner and societal stressors that amplify dysphoria impacting sexual satisfaction. Research, discussed later, shows that sexual partners continuously influence sexual experiences physically and emotionally (Bartolucci et al., 2015; Lindroth, Zeluf, Mannheimer, & Deogan, 2017; Macapagal, Greene, Rivera, & Mustanski, 2015; Preston, 2012). Bertalanffy, the father of *General Systems Theory* (1968) introduced the idea that systems are open and connected to subsystems that have ongoing back and forth relationships. This systemic thinking creates the understanding that trans people interact with larger systems that influence their identity, such as

acceptance or rejection from family members. Considering a systemic framework, clinicians can step outside of solely examining the individual, and consider the multiple systems that influence a trans masculine person's experience. Trans masculine people and their sexual partners constantly take information in from the multiple layers of systems to which they belong. Interactions through words and behaviors create systemic patterns influenced by cultural and social systems. Additionally, there are sociocultural systems at play between partners, which influence expectations of a trans masculine identity (Bethea & McCollum, 2013). Problems are often in the context of systems (Walsh, 2012), highlighting the necessity to consider the role of the sexual partner in relation to transgender congruence and sexual satisfaction.

Relevant clinical literature notes that a trans masculine person may have many social relationships and/or sexual partners who are intimately involved with their identity, especially during times of transition (Lev, 2018). In this regard, not only does the trans masculine person's experience of sex and their gender identity affect their partner(s), but also their partner's experience influences the trans masculine person. This interaction illuminates the influential process of multiple systems that provide both positive and negative feedback within relationships (Boughner, Mims, & Hecker, 2014). Specifically, within a sexual relationship, the partner of a trans masculine person has the power to create security through acceptance or insecurity through rejection (van de Brink, Vollmann, Smeets, Hessen, & Woertman, 2018).

### **Minority Stress**

Oppressive systems may create external and internal stressors for trans masculine people. Intersectional identities such as age, gender identity, class, race, sexual orientation, and/or disability may intensify oppression (McGeorge & Stone Carlson, 2011). The Minority Stress Model (Meyer, 2003) highlights aspects of discrimination and prejudice around identity through

perceived and experienced events, which may lead to negative mental health issues. Hendricks and Testa (2012) applied the minority stress model to the transgender population, noting the negative attitudes and stigma received from society. As the transgender population faces negative stressors, *internalized transphobia* is heightened (Rood et al., 2017). Internalized transphobia is the internalization of negative external messages that forms negative views of self and gender identity (Testa et al., 2017).

Minority stress experienced by trans masculine people may include experiences of physical violence, micro aggressions, and/or verbal discrimination (Austin & Goodman, 2017). This experience may also include perceived anticipation of mistreatment or expected rejection, creating anxiety around gender identity. These external situations may create a pressure to conform to certain sexual/gender roles or pursue medical intervention because of society's expectations around masculinity (Iantaffi & Bockting, 2011), which could lead to increased dysphoria. External stressors may develop into deep internalized feelings of low self-worth and negative beliefs around having a transgender identity.

The exposure of minority stress may lead to acts of resilience and coping skills for some marginalized people. For example, because trans people are exposed to discrimination based on their gender identity, they may develop social skills or form communities with other trans people and/or allies that buffer against society's negative messages. This systemic approach of resiliency creates a connection between trans people by building and connecting through hope and strength (Meyer, 2015). Resiliency may include participating in acts of social justice, connecting in community spaces, or sharing firsthand experiences through interviews.

## **Gender Affirmative Lens**

Minority stress can have a profound influence on self-esteem in relation to gender identity. In order to promote resiliency as an ally, it is important to remain affirmative. As a therapist and researcher, I am persistent in following a gender affirmative approach with my clients and research participants. Many participants may occupy social locations with identities that often experience discrimination in sociocultural and familial systems. This discrimination or minority stress influences their perception of self, leading to negative mental health outcomes such as anxiety and/or depression (Meyer, 2003). Ritter and Terndrup (2002) describe affirmative psychotherapy as a model of accepting all people and remaining free of prejudice. This affirmative approach later influenced a more gender inclusive model, labeled the *Gender Affirmative Model* (GAM) (Hidalgo et al., 2013). This affirmative model provides a framework for the study of accepting fluidity and diversity, remaining nonpathological, and supporting all experiences of gender identity.

As an affirmative researcher, I am able to validate, respect, and offer empathy to those who have not had a space of acceptance prior. It is my hope that my research will help transform these negative internalizations and oppressive messages by affirming these realities (Green & Mitchell, 2015). I aim to use this study to provide research for the community, creating dialogue around shared experience and resiliency by examining how trans masculine people experience sexual satisfaction despite low transgender congruence. Building a study that represents shared struggles through resiliency can offer hope for the community, create understanding, and provide valuable insight for therapists working with trans masculine clients. Identities form within the person, including an array of intersectional identities influenced by multiple systems. As the researcher, I value the multiple realities and diverse gender identities of participants in this study.

Nagoshi and Brzuzy (2010) highlighted identity forming within a person, as no two are alike, declaring differences as natural. Therefore, it was important to expand this study to include all trans masculine identities, considering that both binary and non-binary trans masculine identities are valid.

Gender identities are not immune to influence from external contexts such as language, culture, and history (Hidalgo et al., 2013). Providing a study that specifically aimed to examine intimate details of sexual experiences for trans masculine people can create aspects of affirmation and resiliency (Applegarth & Nuttall, 2016). It was intentional to not center cisheteronormative literature and frameworks regarding sexuality as trans masculine people have vastly different sexual experiences. The outcomes of the study aimed to validate all participants' lived experience, remain inclusive, and examine both the mental and physical experiences of gender embodiment (Hausman, 2001). Activism can present itself through curiosity of experiences for marginalized populations (D'Arrigo-Patrick, Hoff, Knudson-Martin, & Tuttle, 2017); it is my hope that by examining these relationships, participants felt validated in their gender identity. The frameworks presented (i.e., General Systems Theory, minority stress, and gender affirmative lens) work together to highlight research of marginalized community's experiences.

### **Significance of the Study**

#### **Clinical Implications**

In the past, transgender clients were reluctant to pursue therapy for fear of judgment and distrust of mental health providers gatekeeping services (Benson, 2013). Awareness of these issues creates better therapeutic outcomes moving forward. Transgender clients pursue therapy for a number of different reasons. Transgender clients may seek therapy for general concerns

such as anxiety, life stressors, or depression. Often therapy may include discussing topics unrelated to transitioning or gender identity. Additionally, transgender people may seek therapy for transition support, such as medical transition, or family/partner challenges related to transition. A therapist can provide services to obtain medical transition through a letter for hormone therapy and/or a surgical letter (Hendricks & Testa, 2012). The World Professional Association for Transgender Health (WPATH) developed Standards of Care for medical treatment options for transgender people (Coleman et al., 2012). Therapists' privilege of writing these letters warrants a deeper understanding of transgender issues and options for transition (Bockting, Knudson, & Goldberg, 2006).

In counseling and therapy fields, graduate students' training often only includes one course that addresses sexual issues (Rutter, Leech, Anderson, & Saunders, 2010). Specifically, couple and family therapists have responded with feeling unprepared to discuss sexual health with clients (Harris & Hayes, 2008). Given the minimal training across fields, many therapists and supervisors may have a difficult time discussing sexual issues. If this discomfort is present in working with heterosexual, cisgender clients, gender and sexual minority clients might bring additional discomfort (Ritter & Terndrup, 2002). Clinicians should approach sexuality with an affirmative lens, recognizing the sexualization that trans people often face in society. It is important to remain cognizant and sensitive of this experience and address this topic only when clinically relevant.

It is important to increase understanding of trans identities outside of the gender binary. Many therapeutic and human sexuality fields construct gender and sexuality based on binary, heterosexual, cisgender constructs grounded in ideas based on procreation (Iantaffi & Benson, 2018). In training, therapists briefly explore sexual issues and courses often do not include

conversation around transgender sexuality (Rutter et al., 2010). The lack of sexual literature on transgender clients poses a risk of therapists not being properly informed to work with this population. It is especially detrimental when the main issue a client presents is sexual issues within their relationship. Clinicians have a duty to educate themselves and increase competency by consulting with others and educating self with available resources (Hendricks & Testa, 2012). Therapists should remain up to date on not only terminology, but also ongoing medical advancements and medical referrals for transgender clients for GCS.

Addressing sexual health with cisgender and transgender clients is an important part of clinical practice. Clinicians should be prepared and competent in working with clients of any gender identity. Spencer and Vencill (2017) noted there are barriers for transgender people to access proper mental health care in a positive affirmative space to discuss sexual issues. In the past, trans people have been plagued with negative stereotypes such as focusing on HIV/AIDS, ignoring the importance of sex positivity for a marginalized population. Additionally, the vast majority of research that is applicable to transgender people and sexuality aims at exploring sexual satisfaction preoperative versus postoperative GCS (van de Grift et al., 2017; 2019).

It is important to adjust this trajectory, providing affirmative care for clients who may reveal intimate sexual experiences. As Raj (2002) suggests, mental health providers must remain respectful and collaborative, providing comprehensive care for all trans people. Since existing research addresses sexual related issues with mostly heterosexual and cisgender clients (Spencer, Iantaffi, & Bockting, 2017), it is important to consider the multiple intersections and identities that clients bring into therapy. In order to remain competent, it is important to fill the gap in literature and understand the ways transgender congruence influences sexual experiences of trans masculine people. Since current literature is lacking on transgender congruence and sexuality in



the trans population, literature reviewed includes samples of cisgender men addressing body image and sexuality.

## **Background**

Although trans masculine people have a wide array of experiences that are different from cisgender men, the impact of societal messages and body comparison creates a parallel. Often when one's body is the focus or on display during sexual activity, concerns around body image can arise (Milhausen, Buchholz, Opperman, & Benson, 2015). These negative attitudes around body image can create negative sexual experiences (van de Brink et al., 2018). For trans masculine people with low transgender congruence, this external experience of societal standards of masculinity may amplify dysphoria, influencing their sexual satisfaction.

The exposure of media images for cisgender men creates a need to evaluate themselves based on critiques by women or other men (Strelan & Hargreaves, 2005). According to research, these critiques and comparisons to the media around body image lower self-esteem and sexual confidence. Additionally, societal standards of masculinity, or prescribed gender roles around ways of acting out biological sex, influence sexual scripts (Plummer, 2005). Muscularity, highlighted in the media, creates the drive to become bigger and more muscular (Daniel & Bridges, 2013), obtaining a V-taper with broad and chiseled shoulders, chest, back, and arms. Research indicates that cisgender men actively struggle with their physical appearance in relation to sexual activity (Wiederman, 2002). Therefore, the connection between body image and sexual satisfaction in both cisgender men and women (Woertman & van den Brink, 2012) suggests that additional body image concerns created by low transgender congruence in trans masculine people could influence sexual satisfaction.

This introduction has highlighted the need to examine the experiences of transgender congruence and sexual satisfaction with regard to the role of sexual partners for trans masculine people. Historically, the transgender population was neglected in addressing sexuality outside of postoperative sexual outcomes. As the majority of sexual issues literature highlights the cisgender population, other gender identities, such as trans masculine people should also receive attention. This population often experiences low transgender congruence, affecting navigation of sexuality. This study provides crucial information and raises awareness for clinicians using a trans affirmative approach when addressing sexual issues for trans masculine people.

### **Aims**

The purpose of this study was to examine the impact of transgender congruence on sexual satisfaction through the role of affirmative sexual partners. The goal was to gather a clear understanding of how transgender congruence influences sexual satisfaction in trans masculine people of diverse sexual identities. It is important to provide a trans affirmative lens that normalizes experiences and provides helpful information for an audience of clinicians and the trans masculine community around navigating sex. Since research has indicated that sexual dissatisfaction is associated with low quality of life (Chao et al., 2011), it is important to highlight aspects of resiliency and community connectedness to increase transgender congruence, increasing sexual satisfaction. In order to advance the field of couple and family therapy, sexual literature applicable to the transgender population is needed to create a sense of empowerment and community around sexuality (Spencer & Vencill, 2017).

This study examined the relationship between transgender congruence, sexual satisfaction, and affirmative sexual partners. Correlations and PROCESS analyses addressed the following research questions: *Is there a relationship between transgender congruence, affirmative sexual*

*partners, and sexual satisfaction? Do affirmative sexual partners moderate the relationship between transgender congruence and sexual satisfaction?* The research questions were grounded in General Systems Theory, Minority Stress Model, and a gender affirmative lens. The following literature review provides context to the research questions, addressing literature related to transgender congruence, sexual satisfaction, and sexual partners.

## **Chapter Two**

### **Literature Review**

In this chapter I expand on the theoretical frameworks and variables in the study. First, minority stress explains the discrimination that trans masculine people experience, which in turn leads to negative mental health outcomes but also aspects of resiliency. Following this, literature expands on the three variables transgender congruence, sexual satisfaction, and sexual partners.

#### **Minority Stress Model**

Meyer's (1995) original article, in which he developed the minority stress model, illustrated the detrimental effects of a minority status on psychological health in gay men. Minority stress is derived from external and internal stressors through discrimination and prejudice of having a minority status. Meyer (1995) suggested that sexual minorities, such as gay men, often receive discrimination and stigmatization in society. These external experiences then contribute to internalized homophobia and negative attitudes towards their sexual identity (Meyer, 1995). Meyer's (1995) results indicated that experiences of rejection and discrimination, and expectations of discrimination predicted high levels of distress. Therefore, gay men were not only experiencing discrimination, but expected to continue experiencing it based on their sexual identity. This minority stress model provides a solid framework applicable to sexual minorities and transgender people.

Proximal stressors and distal stressors are the processes within the minority stress model. Distal stressors are objective experiences of external events such as discrimination, violence, or rejection that occur because of minority status (Testa, Habarth, Peta, Balsam, & Bockting, 2015). Additionally, distal stressors include the hypervigilance of these events reoccurring, or assuming a person is a target for prejudice. Proximal stressors are the subjective internalization of negative

prejudice and attitudes, which may result in hiding an identity (Meyer, 1995). For sexual minorities, Meyer (2003) used the minority stress model to expand on a study that included a gay, lesbian, and bisexual sample. He found that stressors led to an increased prevalence of negative mental health outcomes. The experienced social stressors were connected to stigma and prejudice creating negative perceptions of sexual identity.

**Transgender minority stress.** Hendricks and Testa (2012) adapted the minority stress model (Meyer, 2003) to the transgender population. Their article provided a framework and deeper understanding of trans people's experiences from an intersectional lens, providing implications for better clinical practices. The minority stress model documents experiences of physical and sexual violence, substance abuse, and suicide attempts all found exceedingly high in the *2015 US Transgender Survey* (James et al., 2016). This report highlights the experiences of prejudice, discrimination, and abuse that transgender people face. In regards to health care findings, 33% of those who saw a health care provider reported a negative experience related to their transgender identity (James et al., 2016). Additionally, transgender people may experience discrimination based on basic rights such as bathroom usage, employment, medical care, legal rights, misgendering (McLemore, 2015), or not being affirmed in their correct gender (Testa et al., 2015). Testa et al. (2015) found that proximal stressors from these external experiences were associated with negative mental health outcomes such as depression and anxiety. These negative evaluations of self, produced through minority stress are referred to as internalized transphobia, or negative views of self-and/or other transgender people (Breslow et al., 2015).

In considering the impact of minority stress, studies have expanded on the direct effects of this model. Sandil, DeBlaere, Breslow, and Eklund (2017) used the minority stress model to examine body image concerns for sexual minority men. In another study, Brewster et al. (2017)

found that the minority stress variable was positively correlated to body dissatisfaction, driving excessive body surveillance and exercise. For this population, minority stress often develops into internalized standards of attraction and a focus on physicality. The toxicity of stigma and prejudice leads to negative mental health issues, concealing sexual identity, and internalized heterosexism (Meyer, 2003). Although the sample consisted of cisgender men, trans masculine people who identify as queer, bisexual, or gay may also experience the same body dissatisfaction.

Body image and minority stress has also been explored with a trans masculine sample (Velez et al., 2016). Research shows that trans masculine people are found to have body image concerns perpetuated by minority stress and masculine body ideals. Norms of masculinity are often set through media and social networks, creating environments of toxic masculinity focused on performance and body standards. In a trans masculine sample of 304 participants, the authors found that the emphasis on male sociocultural body image standards increased distress and lowered body satisfaction (Velez et al., 2016). This study also focused on transgender identity congruence, finding that body congruence played a role in mediating the effects of minority stress.

***Clinical insight.*** Given these stressors, it is important that therapists are aware of the factors discussed in the minority stress model. Hendricks and Testa (2012) explained that as clinicians approach these topics, acceptance and support is helpful in creating a positive therapeutic experience. By focusing on a minority stress model, trans masculine people are less pathologized and more understood from a systemic lens (Scandurra, Amodeo, Valerio, Bochicchio, & Frost, 2017). Timmins, Rimes, and Rahman (2017) noted that rumination occurred between minority stress and psychological distress. These results indicated that one

discriminatory incident could continuously affect a transgender person, leading to an ongoing experience of minority stress. It is important to note that body dysphoria that leads to low transgender congruence is an additional variable not influenced by minority stress. Body dysphoria creates another layer of psychological distress in addition to the implications of minority stress (Timmins et al., 2017).

**Relational minority stress.** Trans people often experience discrimination, or minority stress that negatively impacts their mental health. This minority stress can be a systemic experience that interferes with romantic or sexual partners (Skinta, Hoeflein, Munoz-Martinez, & Rincon, 2018). Coppola (2019) noted the limited amount of research on trans-including couples, yet the impact that minority stress and gender minority stress can have on these couples. In this study she explored fairness and emotional bonding through a minority stress framework for transgender women and their cisgender partners. Coppola (2019) found that trans including couples often experience relational minority stress as a unit in family of origin systems and the broader society. In turn, the emotional bonding is strengthened during these times, offering resiliency for the couple.

As a trans masculine identified partner is exposed to external stressors, the other partner, trans identified or not, often equally experiences the same stressors. Gamarel, Reisner, Laurenceau, Nemoto and Operario (2014) further explored this dyadic experience of the relationship. The authors explored relationship quality that was impacted by discrimination for transgender women and their cisgender male partners. This influence of minority stress, specifically around transgender-related discrimination and relationship stigma were associated with both partner's mental health (Gamarel et al., 2014). This study found that minority stress increased depressive distress and decreased relationship quality. Their findings illustrated the

importance of remaining systemic in treatment. Relationship discrimination and minority stress can intervene with the trans person and their partner's wellbeing. This experience of discrimination of the romantic relationship could create stress, leading to conflict and feelings of isolation for the trans partner (Gamarel et al., 2014). In sum, systemic frameworks help provide insight on the impact of minority stress on romantic partners, or relational minority stress.

Trans people not only experience discrimination in the broader society, but often experience intimate prejudice from partners, lowering relationship satisfaction (Otis, Rostosky, Riggle, & Hamrin, 2006). Minority stress is a systemic experience, as partners who internalize these interactions create negative views of their own relationship. This can lead to conflict or the desire to conform sexually according to society's gender roles, creating a strain in the relationship (Platt & Bolland, 2018). Unfortunately, from these stressors, partners could also be responsible for micro aggressions or subtle transphobic comments within the relationship (Timmins et al., 2017), leading to intensified negative feelings about the relationship or gender identity.

**Resilience.** Despite the negative implications outline through the minority stress model, transgender people often develop resilience. Research by Scandurra et al. (2017) found that although trans people experience discrimination, which creates internalized transphobia and increases mental health problems, they are resilient. Scandurra et al. (2017) noted that resilience moderates the relationship between social stressors and psychological distress. Resilience may include occupying spaces of shared emotional support and community connectedness (Testa et al., 2015). Individual resilience can include higher levels of coping, self-esteem, and pride in identity. Breslow et al. (2015) tested minority stressors, such as internalized transphobia, with resilience and collective action. The authors found that collective action or group activities, in



order to enhance or lead to equal opportunities for trans people in society moderated distress caused by discrimination. Meyer (2003) noted that social support and feeling connected to others moderates the relationship between minority stress and distress. When support systems provide support and affirmation, resiliency of transgender people increases and negative mental health symptoms decrease (Bockting et al., 2013). Research suggests that not only does social support positively influence well-being, but also can reduce negative mental health symptoms of anxiety and depression (Pflum, Testa, Balsam, Goldblum, & Bongar, 2015). Support from family members, friends, partners, and other social support networks can be a protective factor and promote resilience in the face of minority stress.

### **Transgender Congruence**

Embodying a trans masculine identity may include experiences of low transgender congruence resulting in body dysphoria that not only negatively influences self, but self in relationships. Clinicians and researchers note that body dysphoria can also affect the sexual self as body incongruence hinders the enjoyment of sex influencing sexual interactions with self and others (Lev & Sennott, 2012; Nikkelen & Kreukels, 2018; Spencer, Iantaffi, & Bockting, 2017). Lev (2004) defines body (i.e., gender) dysphoria as the pain, distress, and discomfort that trans people often experience in regards to anatomical incongruence. This physical and psychological disconnect may create challenges in obtaining a positive view of sexuality (Spencer & Vencill, 2017).

**Medical research.** Studies have incorporated biological implications of transgender experiences of dysphoria. Studies using brain imaging to record brain activity in transgender versus non-transgender samples show the power behind dysphoria. Case, Brang, Landazuri, Viswanathan, and Ramachandran, (2017) suggested through their highly advanced study, that

differences in neural representation are present when the chest was stimulated in trans masculine samples versus cisgender females. The results of this study indicated that in the trans masculine sample, sensory responses were reduced in both the supramarginal gyrus and secondary somatosensory cortex. In other words, the trans masculine samples experienced lower direct sensation in their chest implying the power of the brain in dysphoria.

Research suggests that body dysphoria creates ongoing distress and body dissatisfaction. Turan et al. (2018) conducted a longitudinal study of hormone therapy with a trans masculine sample. In their study, they found that body uneasiness and psychopathological symptoms of distress were higher in their trans masculine sample than other individuals assigned female at birth. Specifically, trans masculine people may experience body dissatisfaction with regard to genitalia. Becker et al. (2016) found that sex-specific body parts are relevant for those who experience dysphoria and dissatisfaction was higher among sexual anatomy than facial features in trans masculine people.

**DSM-V.** The transgender community is often in disagreement about the inclusion of the diagnosis of *Gender Dysphoria* in the Diagnostic Manual of Mental Disorders 5<sup>th</sup> Edition (DSM-V) (American Psychiatric Association, 2013). The DSM-V defines gender dysphoria as the marked incongruence between one's internal gender and one's sex characteristics leading to distress and the desire to alter secondary and primary sex characteristics (American Psychiatric Association, 2013). This diagnosis on one hand can express the severity of dysphoria, but also create negative stigma. However, with this diagnosis, insurance and medical coverage becomes more accessible. The shift to replace gender identity disorder with gender dysphoria aimed to avoid stigma and highlight significant distress associated with dysphoria. In other words, it is the distress experienced between internal gender identity and physical appearance in regards to

primary and secondary sex characteristics that creates the distress. Bockting et al. (2016) note that transgender is an identity, not a disorder, and dysphoria is only applicable to those who experience distress from the incongruence between gender identity and physical attributes. Schleifer (2006) explored the intersections of sex and gender on gender identity with a sample of gay trans masculine people. The relationships of these identities coincide with one another, as one participant painted a picture of the power of dysphoria by discussing his inability to look in a mirror.

**Increasing transgender congruence.** In order to increase transgender congruence and relieve dysphoric symptoms, trans masculine people may pursue hormone therapy with testosterone, chest reconstruction, and/or gender confirmation surgery (Lev, 2004). Meier, Fitzgerald, Pardo, and Babcock (2011) assessed psychological distress in relation to testosterone. The results from this study indicated that trans masculine participants who were on testosterone, not limited to any specific time period, had fewer negative psychological symptoms, higher resiliency, and higher quality of life than the national mean. Considering their sample and the implications of hormone therapy, the findings suggested that testosterone helped reduce psychological distress. Research suggests that testosterone has an effect on overall mental health and body satisfaction. Davis and Meier (2014) found that individuals who were taking testosterone had fewer negative mental health symptoms such as anxiety and depression than participants who were not taking testosterone. Additionally, Turan et al. (2018) found that testosterone greatly reduced negative mental health symptoms and overall body uneasiness associated with dysphoria. These studies indicate that testosterone can increase transgender congruence, improving the lives of trans masculine people.

**GCS.** Gender confirmation surgery also increases transgender congruence. Research by De Cuypere et al. (2005) found an increase in masturbation, sexual satisfaction, and orgasm after surgery. De Cuypere et al. (2005) also highlighted that body image dysphoria was present before surgery affecting sexual activity. The authors also found that a masculine chest produced male-like motivation and desire to be masculine through outlets such as fitness. In addition, top and bottom surgeries often produce additional physical changes than from testosterone alone (Rachlin et al., 2010). Top surgery led to more positive body satisfaction and positive experiences, which could affect sexual interactions. However, the study neglected to explore the role of the sexual partner, nor the experience of surgical interventions on sexuality.

Trans people may experience such intense dysphoria that they choose to abstain from sexual activity until after GCS (Iantaffi & Benson, 2018). Previous studies examined surgical interventions in regards to reducing body dysphoria. Van de Grift et al. (2016) assessed the effect of mastectomy on body image before and after chest reconstructive surgery. Prior to surgery, body satisfaction and self-esteem were low, but after surgery, dysphoria decreased, and body satisfaction associated with passing improved quality of life. Rachlin et al. (2010) found that hysterectomies and oophorectomies (removal of the ovaries) greatly reduced dysphoria. Their participants reported that these reproductive organs were not congruent with the sample's trans masculine identity. Becker et al. (2018) in a sample of transgender adults, including 62 trans masculine participants, noted the distress and overall body dissatisfaction that arises from dysphoria. The findings from their study suggested that both hormones and surgery were beneficial for improving body image and gender congruence.

Some trans masculine people may obtain transgender congruence through transition. Transgender congruence highlights the connection of the mental and the physical through

medical transition. As body comfort increases post transition and internal gender becomes physically aligned, sexual performance, identity, and fantasies may change. Societal messages dictate that a penis equates to manhood, many trans masculine people resist phallocentrism (i.e., having a penis equals being a man) (Schilt & Windsor, 2014). They may not desire bottom surgeries, with the understanding that surgery does not determine gender experience. Nagoshi and Brzuzy (2010) describe this phenomenon as physical embodiment, which is the experience of the mind connecting to the body, representing the internalized self.

**Societal implications.** Dysphoria is a powerful, often debilitating experience amplified by the body and through sociocultural body standards and norms. Self-worth may form based on meeting these standards of appearance, dictating desirability for potential partners (Brown & Graham, 2008). Studies with populations of cisgender men have found that objectification and societal standards of appearance create body dissatisfaction. Within a cisgender sample, Schooler and Ward (2006) found that up to 43% of men were dissatisfied with their bodies. The authors investigated the role of the media in relation to body attitudes and found that media use reduced comfort with their bodies. Further, comfort contributed to greater sexual assertiveness and comfort in sexual relationships. As the media promotes thin, yet large muscular physiques, men reported becoming preoccupied with achieving these standards. These negative body attitudes often create distress, as Brown and Graham (2008) noted the connection between low masculinity and low body satisfaction. This low satisfaction led to excessive exercise in the gym, striving to obtain these standards in their sample of gay cisgender men.

**Body dysmorphia.** Another aspect that can influence a trans masculine person's perception of their body is body dysmorphic disorder. Body dysmorphic disorder is the preoccupation with perceived flaws in physical appearance that are not observable, resulting in

significant distress (American Psychiatric Association, 2013). For those that are assigned female at birth, and are socialized as female during their formative years, there is extreme societal pressure to retain a certain body image. Literature states that body image concerns from sociocultural appearances pressures may lead to disordered eating and body dysmorphia, most prevalent in adolescents assigned female at birth (Rodgers, Paxton, & McLean, 2014). Therefore, those that are assigned female at birth may be preconditioned to body image concerns leading to a preoccupation following transition to trans masculine. Bowman (2018) explored the lived experience of transgender individuals with eating disorders. The author found that this experience is often a complex interaction of internal body perceptions and external societal messages. For trans people, gender presentation may result in specific dietary restrictions to repress unwanted traits associated with femininity (Bowman, 2018). For example, maintaining a low body weight to prevent the development of breasts or larger frame that accentuates a feminine physique.

Those assigned male at birth are not immune to sociocultural body image standards, and also can experience body dysmorphia. Those assigned male at birth more commonly experience muscle dysmorphia, or the preoccupation that their body is too small or not muscular enough, leading to distress (American Psychiatric Association, 2013). Leit, Gray, and Pope (2002) found that the media greatly influences cisgender men's perception of their bodies. In their study they explored exposure to media, with participants perceiving their muscularity significantly lower than the media images. Literature regarding the connection between body image, body dysmorphia, and disordered eating for those that identify as trans is limited. Body perception is often complicated by both body dysmorphia and body dysphoria, making the two difficult to separate and interact with one another (Bowman, 2018). Combining these gender sociocultural

body standards, someone that transitions from female to male may experience extreme hypersensitivity to their body image, in addition to the distress they already experience from body dysphoria.

Research suggests that society's standards of cisgender male ideals and norms amplify dysphoria for trans masculine people (Velez et al., 2016). Velez et al. (2016) highlighted not only minority stress, but also the implications of objectification theory, or sociocultural standards of masculine attractiveness. Within this study, these standards caused an increase in compulsive exercise among the sample, striving to obtain societal ideals of attractiveness. Medical transition (e.g., testosterone & chest reconstruction) often produces a masculine appearance and cultured genitals relieving dysphoria and stress of perceived sex assigned at birth by producing a more masculine appearance (Schilt & Windsor, 2014). However, the barriers to trans affirmative health care, anxiety, financial situations, complications, and fear of postoperative changes often limit surgeries (Yerke & Mitchell, 2011).

**Relational sexual implications.** The self also undergoes a sexual change during transition that Schilt and Windsor (2014) labeled *sexual habitus*, the physical and mental journey around sex through time. This journey often includes sexual relationships and interactions both positive or negative that help form their sexual self. This connection of the mental and physical self creates unity, increasing transgender congruence. It is the mental experience and imagination that often drives dysphoria away, despite physical parts not being aligned (Langer, 2014). Hansbury (2017) described experiences of transgender embodiment through the phantom penis, the feeling and mental representation that makes the body available for sex. Further mental experiences have been studied by Ramachandran and McGeoch (2008), exploring how participants construct internal gender identity despite mismatching external genitalia, as 60% of

participants reported phantom penises. Trans people often report imagining themselves as a different person or with different parts in order to be sexually satisfied (Doorduyn & Van Berlo, 2014). The inherent maleness is often expressed through sexual dynamics. Latham (2016) explored multiple trans men's sexual narratives during sexual activity who utilized their partners' affirmation to produce inherent maleness through language and sexual activities.

In regards to relational sexual experiences, Iantaffi and Bockting (2011) found that trans masculine people were more likely to express genital discomfort, prefer to have sex in the dark, and dislike discussing their parts. Doorduyn and van Berlo (2014) explored sexual experiences of trans people. Their participants reported avoiding sex or certain sexual behaviors, being touched on certain parts of their body, vivid imagination, prosthetics, language congruence, and/or focusing on their partner to have a more positive sexual experience. The genital distress, related to using the most intimate body part that is associated with sex, may create such strong distress that some participants even withdrew from sex completely. De Cuypere et al. (2005), also found that prior to medical transition, many trans masculine people shut down physical touch with self and other, explaining that their body felt foreign and wanted nothing to do with using it sexually.

***Sexual desire.*** However, as transgender congruence increases through medical transition, specifically the use of testosterone, trans masculine people report an increase in sexual desire. Irwig (2017) describes the goal of testosterone therapy to achieve testosterone concentration in the blood that are parallel to cisgender male's levels according to age. This introduction to testosterone in those assigned female at birth often introduces an increase in motivational desires for sexual activity and sexual thoughts (Wierckx et al., 2011; Klein & Gorzalska et al., 2009). De Cuypere et al. (2005) found that gender reassignment surgery and



testosterone also increase sexual desire. For trans masculine people desired effects of testosterone often include an increase in sexual desire along with bottom growth. Wierckx et al. (2011) measured blood samples of trans masculine people finding that the increase in sexual desire was the result of testosterone and gender confirmation surgery. Sexual implications for this increase in desire resulting in more frequent masturbation and partnered sexual activity, with testosterone levels in normal physiological range as cisgender men (Wierckx et al., 2011). This sample found an increase in sexual wellbeing from to the relief of gender dysphoria leading to more sexual relationships.

It is important to highlight that there may be sexual discrepancies between partners, meaning one partner has a high sex drive and the other partner has a low sex drive. For example, those that are not trans masculine identified may have varying degrees of sexual desire that contradict the trans masculine partner. Partners of trans masculine people, especially cisgender women, as research implies (e.g., Laumann, et al., 2005), may experience lower sexual desire influencing the sexual relationship. It is possible that through medical transition, these mental representations of the sexual self create an ability to perform sexually. By examining sexuality beyond the body's exterior, a connection is made with the mental and transitioned physical self.

### **Sexual Satisfaction**

Sexual issues remain an important topic of discussion in couples therapy (Timm, 2009). Specifically, clients may seek therapy to increase communicating needs and desires to increase sexual satisfaction within the relationship. Sexual satisfaction can be used as a measure for both individual and relational well-being within the relationship. However, there remains an unstructured definition and measure for sexual satisfaction as it can mean different things to different people (Schwartz & Young, 2009). In addition, for those who experience limited

sexual rights by not having the body parts that complete their gender identity, there are further limitations around defining sexual satisfaction (McClelland, 2010). Therefore, this sexual satisfaction literature review will remain gender affirmative referencing studies with LGB populations that focus on intimacy as the outcome for sexual satisfaction; stepping away from cisheteronormative sexual satisfaction research which heavily focuses on orgasm as the marker for sexual satisfaction (Brody & Weiss, 2011)

Sexual satisfaction is a staple in sexuality research but lacks theory, definition, and remains cisheteronormative focusing on married, cisgender male and cisgender female, monogamous populations (Chatterji et al., 2017; McClelland, 2014; Pascoal, Narciso, & Pereira, 2014). Sexual satisfaction is dependent on multiple contexts such as social, political, psychological, physical, and overall quality of life. Pacoal et al. (2014) defined sexual satisfaction as the frequency of sex and orgasm. However, McClelland (2010) offered a more flexible definition in that sexual satisfaction is overall fulfillment of a person's sex life that can positively influence other aspects of their well-being.

**Trans masculine sexual satisfaction.** In regards to transgender identities, often social stigmas can influence sexual behaviors and performance. Current research heightens heteronormative sexuality, measuring satisfaction through cisgender male and cisgender female intercourse (McClelland, 2014). Trans people are not afforded the same sexual rights, of having the correct body parts as cisgender female and cisgender male couples (Herek, 2007). The effects of body dysphoria for trans masculine people influences sexual behavior, which can reduce body accessibility or the need for items to assist in sexual activity (e.g., prosthetic penis). Gender norms not only amplify dysphoria, but also have been found to reduce sexual satisfaction (Bliss & Horne, 2005). In addition, for gender and sexual minorities, it is hard to establish a

concrete definition and measurement of sexual satisfaction as the majority of studies operationalize sexual satisfaction through penis in vagina intercourse (Bridges, Lease, & Ellison, 2004; Meston & Trapnell, 2005). The comparison and evaluation of not having the “correct” sex and attempting to be the “ideal man” through gender conformity (Sanchez et al., 2005) can create additional distress hampering the ability to enjoy sexuality (McClelland, 2010). On the contrary, enacting gender roles and performance as a man, followed by the sexual changes from testosterone such as erections, growth, and more explosive orgasms (Williams et al., 2013) can increase feelings of gender euphoria through erotic satisfaction (Schippers, 2007).

The minority stress model (Meyer, 2003) connects sexual and later gender minority status (Hendricks & Testa, 2012) to experiences of rejection and discrimination leading to increased negative mental health outcomes. It is important to understand the role of gender/sexual norms that shape definitions of sexual satisfaction. A universal definition is not obtainable as sexual satisfaction can mean different things to different people (Schwartz & Young, 2009). Sexual history, sexual education, and sexual experience influence definitions of sexual satisfaction and how people measure their sexual satisfaction. McClelland (2014) states that sociopolitical contexts influence what individuals learn sexually and how we develop what it means to describe and experience sexual satisfaction.

**Sexual satisfaction definition.** Attempting to establish a concrete definition of sexual satisfaction is not obtainable as sexual activities and sexual relationships widely differ. With this being said, the variation of sexual activities causes researchers to use orgasm as the objective measure for sexual satisfaction, which is easily self-reported (McClelland, 2010). Using orgasm to measure sexual satisfaction erases other contributing aspects of sexuality. Orgasm remains biological, neglecting the societal, political, and psychosocial aspects of sexual well-being

(Tiefer, 2001). In addition, using orgasm as the bar frames sexual satisfaction as an individual process, not dependent on interpersonal interactions or circumstances. Sexual experiences include an array of interpersonal aspects that are erased by focusing on physiological objectives (Chatterji et al., 2017). Not all individuals consider orgasm as the primary objective during sexual performance. In addition, this labels the body's physical and physiological responses as the analyzed standard of sexual satisfaction (McClelland, 2010), which may not be obtainable for all trans masculine people who experience dysphoria.

Although studies use orgasm to measure sexual satisfaction, there are other individual and relational factors that could increase sexual satisfaction. For example, in their study of cisgender men and women in same-sex and mixed sex relationships, Holmberg and Blair (2009) found that communication with a partner was essential to their sexual satisfaction. Remaining systemic increased relationship satisfaction and sexual satisfaction; aspects such as emotional closeness and romantic love also increases sexual satisfaction (Kaestle & Halpern, 2007). McClelland (2014) in a study of LGBTQ young adults found that emotional connection largely increased sexual satisfaction. This included feeling safe, trusting a partner, and letting one's guard down. The author found that by feeling emotionally connected to a partner, participants were able to experience greater sexual satisfaction. Additionally, another finding was that a partner's orgasm fulfilled the emotional closeness, which was a key indicator of their sexual satisfaction (McClelland, 2014). This experience was replicated in Martin and Coolhart's (2019) study in which trans masculine participants experienced sexual satisfaction witnessing their partner's pleasure.

**Communication.** Early sex researchers, Masters & Johnson (1970) developed interventions in sex therapy that focused on increasing communication (i.e., sensate focus). This

technique focuses on the physical and emotional awareness of sex versus the (although heteronormative) penetrative aspect. Jones, Robinson, and Seedall (2018) examined 142 cisgender male and cisgender female couples; they found that greater amounts of sexual communication led to an increase in orgasm and sexual satisfaction with both genders. Overall, improved communication and sexual satisfaction has been found to predict overall relationship satisfaction (Yoo, Bartle-Haring, & Gangamma, 2014). The more a partner discloses their sexual preferences, the more sexually satisfying the relationship can be. Mark and Jozkowski (2013) in their study of heterosexual college students found that the level of sexual communication was positively associated with sexual satisfaction. If sexual roles and expectations are neglected early in the relationship, over time, these couples may suffer both from a relational and sexual standpoint (Jones et al., 2017). Sexual communication may be a challenge as power dynamics, gender identities, and emotional safety can dictate the level of comfort in discussing these needs. For example, for a trans-identified couple, the trans partner may experience a hesitancy to disclose needs early on in the relationship out of fear. Minority stress and societal gender norms may create an internalized perception of the sexual self, leading to a lack of comfort in vulnerability.

**Emotional dynamics.** Continuing with the theme of communication, additional studies have explored relational and emotional dynamics within sexual satisfaction. Chatterji et al. (2017) provides a systemic definition using a diversified sample of bisexual women, in which they found sexual satisfaction to include emotional security, quality of interpersonal interaction during and after a sexual encounter, mutuality, intimacy, partner skill, novelty, and communication. In prior studies, the same results have been echoed finding that interpersonal

connections, skill, communication, and intimacy are positively associated with sexual satisfaction (Fahs, 2014; Štulhofer, Ferreira, & Landripet, 2014).

McClelland (2014) worked to broaden the understanding of sexual satisfaction using diverse samples. She developed a four-factor model of sexual satisfaction including a 50% sexual minority sample that reflected perceptions of sexual satisfaction (McClelland, 2014). Factor A included emotional security, Factor B relational intimacy, Factor C the partner's physical pleasure, and Factor D orgasm for both partners. Chatterji et al. (2014) replicated the study with elements of sexual satisfaction including emotional attunement (78%) such as communication, comfort, trust, and emotional gratification or intimacy during the interaction making it more enjoyable throughout. The other two elements included partner gratification or the other partner's sexual satisfaction, sensory gratification or partner skill, and bodily sensations for both partners. Perhaps this study can shed light on the experiences of trans masculine people by highlighting the diverse behaviors that can lead to sexual satisfaction. As a population that often experiences sexual distress from body dysphoria, creative sexual scripts must be developed in order to reach sexual satisfaction. The combination of elements from the mentioned studies helps create a more non heteronormative definition and diverts from societal pre-scripted coitus, leading to greater sexual satisfaction.

From studies that have included LGBTQ participants (e.g., Chatterji et al., 2017), there could be a parallel to experiences of trans masculine people. As transgender individuals explore their sexuality, they may find that they deviate from heteronormative scripts. As one bisexual participant noted, "Gender fucking is something [one] loves doing...messes with roles...empowering" (Chatterji et al., 2017, p.894). This excerpt can shine light on the

experience of trans masculine people, using their sexuality to create empowerment, and defining their own sexual satisfaction that goes against society's perceived sexual and gendered roles.

### **Development of Affirmative Sexual Partner Scale**

**Self of the researcher.** As a therapist and researcher, I present with my own epistemology that has formed my decision to not include a focus on heterosexual cisgender literature and the decision to step aside from cisheteronormative sexuality. My definition of sexual satisfaction influences my decision to not only use orgasm as a signifier for sexual satisfaction, rather the New Sexual Satisfaction Scale reflects my definition to include in depth aspects such as arousal, orgasm, pleasure, focus, body response, creativity, variety, needs, surrender, emotionality, balance, and mood. By doing this, trans masculine identities are centered, which include aspects of dysphoria where orgasm may not be possible or desired because of triggering dysphoria. I am reminded of my early experiences in sexual education classes and conversations among peers that were focused on the aspect of cisgender male ejaculation as the end goal of sex. Sexual satisfaction for other genders and sexual satisfaction was often dismissed. As research highlights that orgasm is often the tangible signifier of sexual satisfaction, my definition deviates from this standard. Rather, I acknowledge that often a disconnect or dissociative experience from the physical body happens for trans people. Therefore, trans people may develop a subjective experience that includes intimacy through emotional connection and partner satisfaction.

From an intimacy standpoint I believe that communication, safety, trust, love, and shared closeness create the accessibility to sexual behavior (Holmberg & Blair, 2009; Kaestle & Halpern, 2007). As sex is a very intimate experience to begin with, those who experience a disconnect may struggle at a deeper level to accept themselves as a sexual being. However,

having open sexual communication about needs and desires can lead to greater sexual satisfaction systemically. Additionally, in any relationship, with honesty, communication, and shared intimate closeness, partners can develop safety and trust as romantic love grows.

**Emotional connection.** My definition of including emotional connection replicates findings by Chatterji et al. (2017) to include interaction before, during, and after sexual performance. The quality of mutuality, communication, and respect at the interpersonal level can lead to extremely high experiences of sexual satisfaction (Pascoal et al., 2014). As mentioned above, the four-factor model by McClelland (2014) provides a deeper insight into experiences beyond the physical. The first two factors in this model focus on both relational intimacy and emotional security. I believe that sexual satisfaction is not possible without these two factors; additionally, a sexual experience can lead to increased relational intimacy and emotional security.

**Partner sexual satisfaction.** The last layer of my definition of sexual satisfaction includes the physical satisfaction of a partner. In order to access sexual behavior, trans masculine people need to experience gender euphoria by enacting gender roles, performance, and receiving validation in their gender from a partner (Schippers, 2007). Additionally, it can be the experience of their partner's sexual satisfaction that increases gender euphoria. McClelland (2014) noted the partner's physical pleasure was a marker of sexual satisfaction. Martin and Coolhart (2019) suggested parallel findings as trans masculine participants described deriving their own satisfaction from their partner's visible physical pleasure. In conclusion, my definition of sexual satisfaction is layered by intimacy through emotional connection, pleasure, arousal, orgasm, and a partner's physical satisfaction, in which one cannot exist without the others, and are constantly overlapping. The decision was made to use a scale that incorporated these



variables. Therefore, The New Sexual Satisfaction Scale addressed these variables that parallel my definition of individual and partner aspects such as arousal, orgasm, pleasure, focus, body response, creativity, variety, needs, surrender, emotionality, balance, and mood.

**Increasing sexual satisfaction.** For some trans masculine people, many factors may affect their sexuality and the particular ways they navigate sexual intimacy. Bodies and dysphoria can create a layer of complexity interacting with sexual performance. Iantaffi and Benson (2018) make suggestions of possible issues that may arise in therapy, for example, dealing with genital dysphoria in sexual situations. However, as discussed above, physical embodiment through testosterone, chest reconstruction, and/or gender confirmation surgery can reduce this dysphoria, positively influencing sexual selves (Lev & Sennott, 2012). In a sample of 74 trans masculine people who physically transitioned, Schilt and Windsor (2014) found that a majority of the participants reported that transition improved physical embodiment and the sexual self. Other studies have only addressed sexual performance and surgical interventions. As mentioned above, not only did these studies report reduced dysphoria, but they also provided implications on the effects on sexual activity. Surgical interventions such as mastectomies (i.e., chest reconstruction) were found to improve sexual activity involving the chest (van de Grift et al., 2016) and hysterectomies involving penetrative sex (Rachlin et al., 2010). The authors in both studies found that dysphoria was extremely high prior to surgery, especially during sexual interaction with these body parts.

Despite addressing these surgical interventions, the studies did not discuss sexual satisfaction postoperative and the impact of surgery on sexual activity. Physical changes postoperative could also influence sex life, masturbation, and intimacy (Iantaffi & Benson, 2018). Additionally, those pre-transition may not have a positive experience with their bodies or

fit the sociocultural standard, which influences self-perception, leading to hesitancy to share their body with others sexually. Genitalia could possibly play a role in reducing satisfaction especially in trans masculine people who have not had bottom surgery. It is important to consider these different variables, discussing these topics in literature could assist trans masculine people in increasing transgender congruence and sexual satisfaction.

**Body image and cisgender persons.** It was intentional that research around sexual satisfaction is not focused on cisgender heterosexual literature. However, it is important to highlight the commonalities in masculine culture that amplify body image for both transgender and cisgender men. To begin, Daniel and Bridges (2013) examined the impact of body image and masculinity on sexual satisfaction in college men, finding that during sexual activity, negative body image was a distractor leading to reduced satisfaction during sexual activities. With this being said, there are often expectations of how trans masculine people should behave sexually. Society creates a sexual script pertaining to certain sexual acts and positions, that often eliminate intimacy that for some can create decreased satisfaction. The socialization of men to be dominant and aggressive, may in turn dictate ideals of sexual roles for trans masculine people. Testing body shame and sexual problems, Sanchez and Kiefer (2007) examined cisgender men and women, noting that cisgender men were concerned about appearance, which led to sexual issues. During sexual intimacy, participants reported self-consciousness around their body inhibiting the amount of sexual pleasure they obtained. Body image often interrupted sexual satisfaction and increased the focus on achieving prescribed sexual roles.

***Masculine sexual scripts.*** Studies have noted the impact that instrumental masculinity or adhering to societal standards of what it means to be a man (e.g., being aggressive and sexually assertive) influences sexuality for trans masculine people. During sexual encounters,

trans masculine people may be focused on these sexual scripts and stereotypical performance that then create a distractor around sexuality (Schooler & Ward, 2006). Sexual distress created by body image may lead to compulsivity around achieving a masculine appearance interfering with sexual activity (Velez et al., 2016). While unexplored in the current research, trans masculine people may encounter the same pressures, having to abide by society's unrealistic ideals of a cisgender man's physique and sexual roles.

In a gay cisgender sample, Starks, Grov, and Parsons (2013) explored sexual satisfaction and interpersonal functioning in gay relationships. The results indicated that sexual compulsion was negatively correlated to sexual satisfaction. Daniel and Bridges (2013) found that negative body image was a distractor for cisgender men, leading to an avoidance of sexual activities, and lower sexual satisfaction. The Restricted Activities Scale (REACT) measured body interference with sex, and in a cisgender sample, Zamboni, Robinson, and Bockting (2006) concluded that a positive body image related to higher sexual satisfaction. Although these three studies provide valuable insight for the cisgender population, trans masculine people were not included in the sample. These studies inform an interest in examining applicability to trans masculine people. If body image in cisgender men impedes on sexual satisfaction, trans masculine people experiencing low transgender congruence may have parallel experiences.

**Trans masculine literature.** The depersonalization and pain tolerance that transgender people experience related to their genitals or body (Langer, 2014) may also interfere with sexual satisfaction. However, diverse sexualities may offer different experiences of sexual and body satisfaction as explored by Bauer, Redman, Bradley, and Scheim (2013). In their findings, gay and bisexual men who have sex with men (MSM) reported lower body image worries and low impact of trans specific concerns in sexual situations. On the other hand, Lev (2004) highlighted

the stone butch identity in masculine presenting people assigned female at birth. This identity entails that certain parts of the body are off limits or touched only by partners in a masculine way.

Sexual satisfaction connects to sexual quality of life, as those with low satisfaction have reported poor sexual quality of life. In a clinical sample using the Sexual QoL of the World Health Organization Quality of Life (WHOQOL)-100 of data gathered from 36 trans masculine people who experienced body dysphoria, Bartolucci et al. (2015) found a consistency of low sexual quality of life prior to gender confirmation surgery. The authors also found that hormonal treatment contributed to having a higher sexual quality of life and higher sexual satisfaction. Thurston and Allan (2018) noted that sexual satisfaction increased as trans masculine people became more confident in expressing their sexual satisfaction.

Many trans masculine people have found an increase in sexual desire and sexual satisfaction following gender confirmation surgery. For example, Wierckx et al., (2014) found that a majority of their trans masculine sample (71%) reported higher sexual satisfaction after GCS. Highlighting the role of transgender congruence on sexual satisfaction could assist trans masculine people in navigating their sexual relationship, producing higher satisfaction. In their thematic analysis, Thurston & Allan (2018) reviewed seven studies that addressed sexuality during the gender transition process. Themes included the renegotiation of norms through shifting sexual desires, sexual development, and increased sexual activity. The participants described their body becoming more aligned with their internal gender identity, as what was once fantasy internally, became physical reality. The authors stated, “the more embodied an individual was became reflected in their satisfaction sexually” (Thurston & Allan, 2018, p.44). This sexual satisfaction was often dependent on the partner affirming their gender by

experimentation and familiarity of physical changes; together they co-constructed new sexual scripts.

### **Sexual Partners**

For all gender identities, a partner that affirms their sexual needs can lead to more satisfactory sexual experiences. In literature that includes cisgender populations, personality characteristics such as a secure attachment, honesty, connection, and communication are often regarded as positive partner traits (Bennet, LoPresti, & Denes, 2019; Regan, Levin, Sprecher, Christopher, & Gate, 2008). Both cisgender and transgender sexual relationships have many commonalities as communication around sexual needs is essential. Gender identity and expression are fundamental to sexual relationships as they often dictate sexual attraction and physical intimacy. Intimate relationships are a source of ongoing interactions between gender and sexual identity. Trans masculine people do successfully partner and value relational intimacy (Skinta et al., 2018). In fact, De Cuypere et al. (2005) found in their sample that those partnered had greater satisfaction in their sex life than those who were single. Additionally, Meier, Sharp, Michonski, Babcock, and Fitzgerald (2013) noted that not only do romantic relationships survive transition; they can also reduce negative mental health issues. Supportive relationships during transition can decrease feelings of anxiety and depression, which were found to be greater in trans masculine people who were single.

**Reducing distress.** Research has found that partners play a role in increasing sexual satisfaction and sexual quality of life for transgender people (Bartolucci et al., 2015). Unlike the cisgender literature, for those that are trans identified that experience dysphoria, a partner can aide in reducing distress around dysphoria or other implications interfering with sexual performance (Lindroth, Zeluf, Mannheimer, & Deogan, 2017). However, finding a partner for

trans people often presents difficulty, as Lev (2004) highlighted the importance of finding someone who is “compatible and understanding of body dysphoria” (p.301). The relationship requires understanding and negotiation around the complexity of gender identity. This increase in communication, as Preston (2012) noted, could provide lessons to all, as trans people tend to focus on communication around sexual issues. Together, as Macapagal, Greene, Rivera, and Mustanski (2015) suggest, partners can unpack sexual scripts and sociocultural standards around sexuality.

**Partners of trans masculine people.** Trans masculine people have diverse sexualities and are attracted to many different gender identities (Lev & Sennott, 2012). Historically, medical and health communities assumed trans masculine people were attracted to women and denied any other sexual identity to avoid stigmatization by medical professionals (Mizock & Hopwood, 2016; Rowniak & Chesla, 2013). Partners of trans masculine people may shift their identity or still embody prior identities such as pansexual or queer. Transition often influences sexual partners and they experience the impact of negative body image influencing their partner’s sexual satisfaction. Pfeffer (2008) found that lesbian partners of trans masculine identified individuals often acted hyper-feminine in order to make their partner feel more masculine. This dual body consciousness may create additional dysphoria influencing sexual satisfaction. In the same way, trans masculine people may enact hyper masculine ideals, creating greater distress and interfering with sexual satisfaction.

Clinical literature has highlighted the systemic impact of gender transition through time has many physical, mental, and emotional changes (Lev, 2004). However, the support of a partner can alleviate distress and affirm gender identity. The sexual partner’s affirmation of the trans person in regards to their body and gender can impact sexual satisfaction. Research has

highlighted the need for support and validation of a trans masculine identity within a sexual relationship (Tree-McGrath, Puckett, Reisner, & Pantalone, 2018). This validation can create an increase in sexual openness and confidence in pursuing sexual relationships. Research has found that throughout social/medical transition the sexual relationship is often positively impacted (Joslin-Roher & Wheeler, 2009) and leads to many changes within the sexual relationship (Brown & Graham, 2008). As sexual desire increases, the authors note that self-confidence, assertiveness, and confidence in the relationship increased as well. This research suggests that a partner's attentiveness to transgender congruence and identity needs decreases overall distress and could increase sexual satisfaction.

**Attachment.** A satisfying sexual relationship could intensify feelings of love, security, commitment, and intimacy between partners (van de Brink et al., 2008). Italian studies have explored the role of attachment with a transgender identity (Amodeo, Vitelli, Scandurra, Picariello, & Valerio, 2015; Scandurra et al., 2017). Both studies' findings imply that a secure attachment could decrease sexual distress and improve feelings around identity. This security comes from commitment and affirmation of their transgender identity (Devor, 1993), leading to an increase in self-esteem and confidence in the relationship. The co-transition process affects the partner of the trans person in several ways. As a partner transitions, security is found through acceptance and emotional support from a partner (Theron & Collier, 2013). Additional studies have found the language and identity of a partner to be affirmative of sexual experiences, such as the language that comes with a heterosexual woman (i.e., sexual descriptors for male anatomy) or the ability to penetrate the sexual partner (Martin & Coolhart, 2019; Williams et al., 2013).

**Communication.** For partners where at least one partner is trans identified, it is important to explore language around gender identity within the relationship. Often language

can capture the mental experience of sex and improve sexual satisfaction (Langer, 2014). Iantaffi and Benson (2018) provided case studies of relational therapy with a trans masculine person and his cisgender partner. The authors noted that anatomical terminology for cisgender women does not fit for trans masculine people and can be a source of retraumatization, which can be triggering for clients, disrupting the therapeutic process. This “decentering gendered language for sexual anatomy” (Iantaffi & Benson, 2018, p. 209) is necessary to affirm trans people’s sexual identities and affirm their genders. Trans people can inform their partners of language that fits their gender identity and relabeled using masculine terms (e.g., chest, penis, etc.). By remapping the body to reflect gender identity, mental health and overall adaptation to dysphoria can improve (Tobin, 2003). Recoding these body parts allows the imagined body part to be a part of sexual experiences (Bettcher, 2014). Often recoding these body parts is the only way trans people can be sexually active, which can then lead to satisfactory experiences in sexual relationships (Hale, 1997).

Platt and Bolland (2018) explored romantic partners and relationships with transgender people, finding the necessity for communication. The authors found that sexual intimacy involves communicating their needs concerning body dysphoria and ongoing physical changes that often influences sexual experiences. As primary sex characteristics do not align for trans people, their gender relies on behavior to demonstrate gender identity (Dozier, 2005). However, as stated above, for those who have taken hormones to become congruent with their body, secondary sex characteristics often present strongly, validating their gender. Dozier (2005) also noted that the reciprocity of sexual desire from partners not only affirms gender identity, but also creates an increase in relational security. Together partners can change the nature of their sexual activities with an emphasis on masculinity and communicate around limits and desires, as Brown



(2010) described the need for trans men to express their desires with partners. Sexual partners play an important role in validating their partner's identity, which can lead to increased relational satisfaction.

### **Intersection of Variables**

Prior to conducting this research, I used a qualitative study to inform my theoretical and measurement framework on this study. This study titled "*Because your dysphoria gets in the way of you...it affects everything.*" *The mental, physical, and relational aspects of navigating body dysphoria and sex for trans masculine people* (Martin & Coolhart, 2019) explored the challenges and resilience related to body dysphoria and sexual experiences. The purpose behind that study was to gather a deeper understanding of navigating sexual experiences, which in turn informed the current study. The participants discussed the obstacle of dysphoria that impacted both sexual satisfaction and sexual experiences.

Martin and Coolhart (2019) found that three interconnected themes emerged from the study, including mental, physical, and relational. In other words, during sex, the participants simultaneously experienced body dysphoria. The mental theme consisted of having a mind-body connection, experiencing negative mental health outcomes, and ongoing thoughts about dysphoria. The physical theme included body discomfort, testosterone and gender confirmation surgery, boundaries, prosthetics, self-pleasure, and masculinity. The relational theme included partner pleasing, communication, support, burden around gender identity, and sexual identity. These three themes are constantly interacting, both impacting the trans masculine person and their partners.

This study provided descriptive data on the mental experience that was wrapped up in physical and relational sexual experiences. The participants provided new insight on navigating

dysphoria through physical adjustments with partners (Martin & Coolhart, 2019). This is a large part of sexual satisfaction for trans masculine people as gender identity can rely partners co-constructing their masculinity through communication and behavior during sex, providing affirmation for the trans masculine person, leading to more satisfying sexual experiences. The Affirmative Sexual Partner Scale used the three themes from the study to develop questions that addressed partner affirmation around gender identity during sexual activity.

Sexual issues literature is limited to mostly heterosexual cisgender men and women with the focus often on dysfunction or disorders. With the limited transgender inclusive literature cited, studies have not discussed the three variables of sexual satisfaction, sexual partners, and transgender congruence. The primary goal of this study is to provide information that will be useful to other trans masculine people, their partners, and mental health professionals. Clinicians' competency is of extreme importance as more and more gender diverse clients enter the therapy room. Clinicians need to understand the impact of transgender congruence on sexual satisfaction, which not only affects trans people but also their sexual partners. In order to increase this knowledge, there is a need for further research on understanding the relationship between transgender congruence, sexual partners, and sexual satisfaction.

### **The Current Study**

The literature review highlighted the need to examine the experiences of transgender congruence, sexual partners, and sexual satisfaction in trans masculine people. Past literature neglected the transgender population and rarely addressed sexuality outside of postoperative sexual satisfaction. As the majority of sexual issues literature highlights the cisgender population, attention specific to trans masculine people is needed. This population often

experiences low transgender congruence influencing sexual satisfaction and sexual partners, which could complicate navigation of their sex lives.

The aim of this study is to examine the effect of transgender congruence on sexual satisfaction through affirmative sexual partners. The goal is to gather a better understanding of how transgender congruence influences sexual satisfaction, and the role of affirmative sexual partners of trans masculine people of diverse sexual identities. It was important to provide a trans affirmative approach that normalizes experiences and provides helpful information for an audience of clinicians and the transgender community around navigating sex. This can provide crucial information and raise awareness for clinicians in providing the best mental health care. Providing additional research that addresses sexuality within the transgender population will advance the field of couple and family therapy, creating a sense of empowerment and community around sexuality (Spencer & Vencill, 2017).

## **Chapter Three**

### **Methodology**

In this chapter I described the methodology of the study including the research questions, design, sample, procedure and data collection, measures, and data analyses. This study examined the relationship between transgender congruence, affirmative sexual partners, and sexual satisfaction among a trans masculine sample. It was anticipated the relationship between transgender congruence and sexual satisfaction would be moderated by affirmative sexual partners.

#### **Rationale for Moderator Model**

The moderator model was proposed by referencing Martin and Coolhart's study (2019) in which the variables were found to simultaneously impact one another, with affirmative partners positively influencing their sexual experiences. In this study, descriptive data revealed that affirmative sexual partners had the power to reduce their body dysphoria during sexual experiences which led to an increase in sexual satisfaction. Therefore, the hypothesized path model of moderation displays the relationships of body dysphoria on sexual satisfaction, with affirmative sexual partners as a moderator (Figure 3.1). The independent variable or predictor variable was transgender congruence, which is the degree of appearance congruence and gender identity acceptance trans masculine people may feel about physical attributes. Transgender congruence is viewed as physical appearance, a mind and body connection, and outward perception of gender. The moderator variable was affirmative sexual partners, which was defined as current or past sexual partners and measuring how affirmative the partners were of their trans masculine identity. The dependent or outcome variable, sexual satisfaction, pertained to satisfaction of various aspects of the participant's sex life. Sexual satisfaction addressed

participant and partner’s arousal, pleasure, connection, and orgasm. In summary, the current study aimed to explore the relationship between transgender congruence, sexual partners, and sexual satisfaction for trans masculine people.

### Research Questions

This purpose of this study was to examine the relationships between transgender congruence, affirmative sexual partners and sexual satisfaction.

**Research question one.** Is there a relationship between transgender congruence, affirmative sexual partners, and sexual satisfaction?

**Hypothesis 1.** Transgender congruence will be significantly and positively correlated with sexual satisfaction.

**Hypothesis 2.** Affirmative sexual partners will be significantly and positively correlated with sexual satisfaction.

**Research question two.** Do affirmative sexual partners moderate the relationship between transgender congruence and sexual satisfaction?

**Hypothesis 3.** Affirmative sexual partners will moderate the relationship between transgender congruence and sexual satisfaction.

Figure 3.1 displays the hypothesized moderation path model:

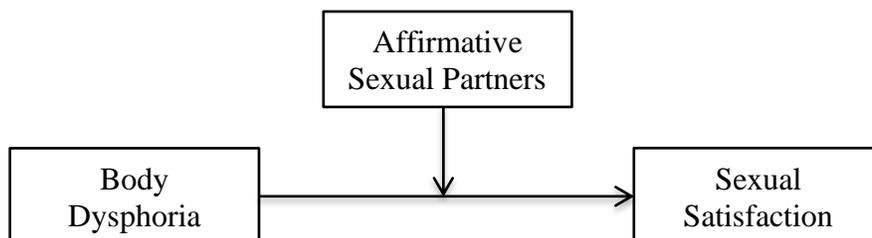


Figure 3.1. Hypothesized Moderation Path Model.

## **Research Design**

A cross sectional correlational quantitative design determined the relationship between transgender congruence and sexual satisfaction, moderated by affirmative sexual partners. This design was suitable because it did not manipulate the variables, but rather observed a natural occurrence. The only projected limitation to this type of methodology is that there was not any prior testing on the variables. However, the existing gap in literature suggested that a connection can be established between all variables. The strength lies in the relevant literature on body dysphoria's influence on overall wellbeing. The analysis included correlations to examine the relationship between the variables. PROCESS analysis (Hayes, 2018) through SPSS calculated the moderation. It was hypothesized that affirmative sexual partners would moderate the relationship between transgender congruence and influence sexual satisfaction.

## **Sample**

The study included a convenience sample of self-identified trans masculine adults. The sample was international and included trans masculine adults from all over the world. The participants were recruited for the study through various transgender community-based sources (e.g., LGBTQ campus/social groups, Facebook, transgender conferences, and mental/medical health care providers). Participation was voluntary and participants were allowed to withdraw from the study at any point. The original targeted sample size was 250 participants; the final sample size immensely exceeded this goal. A total of 1,298 survey responses were recorded. Responses were removed for those who did not meet, or had incomplete responses to the inclusion criteria, the final sample included 1,041 participants.

**Inclusion criteria:** The requirement for inclusion in the sample was:

- At least 18 years old

- Assigned female at birth, but had a masculine gender identity (e.g., FtM, trans man, trans, transgender, non-binary, trans masculine, male, man, genderqueer, etc.)
- Sexually active with a partner in the past or present

### **Procedure and Data Collection**

Data gathered explored the variables of transgender congruence, affirmative sexual partners, and sexual satisfaction. Following approval from the University Institutional Review Board, the survey was available online through Qualtrics for a period of two months before data analysis began. Transgender support groups, mental health providers (i.e., couple and family therapists and licensed clinical social workers), and social media groups received the link for the questionnaire. Flyers were accessible through various national LGBTQ groups, medical/mental health care providers' offices, and various transgender conferences. All participants completed the survey anonymously online with an informed consent page prior to the survey that informed participants of the risks and benefits of the study. A Psychology Today link then provided participants with available therapists by city and state location. The instructions page informed participants about the purpose of the study, why their participation was valuable, outlined the risks and benefits, stated the possibility to withdraw at any time, and provided the approximate time to complete (25 minutes). Following the questionnaire, open-ended questions were asked, "Do items fit your experience?" and "What else would you add?" The questionnaire conclusion page included instruction for participants to forward the link to others who fit inclusion criteria. The researcher then gathered the data via Qualtrics after the two-month period.

## Measures

The measures included a demographic questionnaire, the Transgender Congruence Scale (TCS, Kozee, Tylka, & Bauerband, 2012), Affirmative Sexual Partner Scale (ASPS, Martin & Coolhart, 2019), and the New Sexual Satisfaction Scale (NSSS, Štulhofer, Buško, & Brouillard, 2010). Factor analyses on all measures are discussed in results section.

The target sample size was 250 trans masculine participants. The final number of respondents were gathered through Qualtrics after a period of two months, then generated into Microsoft Word and SPSS. The survey began with an informed consent question and in order to move forward in the survey, participants had to select ‘I consent, begin the study.’ The next four questions assessed the inclusion criteria of 18 years or older, assigned female at birth, trans masculine gender identity, and sexually active currently or in the past. Participants had to answer ‘yes’ to all four questions in order to begin the survey questions, which included: “Are you 18 years of age or older?” “Were you assigned female at birth?” “Understanding that gender identity can be complex and/or constantly evolving, which category describes your current gender identity?” (Participants had the option to select trans masculine binary or trans masculine non-binary). “Have you ever been or are you currently sexually active?”

The demographic questionnaire (see Appendix A) gathered the participants’ gender identity, age, ethno-racial background, sexual identity, location, and personal annual income. Additional demographic questions were asked specifically about medical transition: hormone therapy (i.e., Testosterone), top surgery (i.e., chest reconstruction), and bottom surgery (i.e., Phalloplasty or Metoidioplasty). By intentionally adding demographic questions, the analyses outcomes remained intersectional. The data analyses provided a plethora of diverse responses. This intersectional lens is used in the post hoc analyses to further explore identities. Following



this, the results demonstrated various identities that experience different levels of transgender congruence.

The demographic questionnaire questions were forced choice and assisted the researcher in eliminating surveys that did not meet the inclusion criteria nor were completed. Additionally, ethno-racial background, sexual identity, and location allowed ‘other responses’ with directions for participants to please specify their response. Demographics were included in the Affirmative Sexual Partner Scale, which asked the participants their most recent sexual partner’s age, ethno-racial background, gender identity, sexual identity, and the length of the relationship. In the same way, ethno-racial background, gender identity, sexual identity allowed the option of ‘other’ and to please specify their responses. The last two demographic questions assessed whether or not participants had engaged in therapy for assistance in gender transition and therapy for other life stressors.

**Transgender congruence.** The Transgender Congruence Scale (TCS) (Kozee et al., 2012) (see Appendix B) measured the extent to which participants felt positively about their gender identity and believed their physical appearance was congruent to their identity (e.g., “I am happy that I have the gender identity that I do”). The scale was developed to assess the level of comfort that a trans person feels with their gender identity and external appearance. Participants responded to this survey using a 5-point likert-type scale (1= strongly disagree to 5= strongly agree). To arrive at the total scale score, the responses of the 12 items (reverse scoring items 6, 8, and 10; where 1 = 5, 2 = 4, 3 = 3, 4 = 2, & 5 = 1) were averaged and a higher score indicated a more positive gender identity in regards to appearance congruence and gender identity acceptance. In a study by Velez et al. (2016) the authors supported a high reliability of TCS

scores through the relationship between life satisfaction and depression, finding a Cronbach's alpha of 0.91.

**Affirmative sexual partner.** The Affirmative Sexual Partner Scale is a quantitative measure developed from Martin and Coolhart's (2019) qualitative study on exploring sexual performance and sexual satisfaction in trans masculine people. This scale measured the sexual partner's role in affirming the gender identity of the trans masculine partner (see Appendix C). Themes derived from this study included addressing attachment, affirmation of gender identity, communication, partner pleasing, identity, and feeling of burden around gender identity. Participants used a 5-point likert-type scale (1= strongly disagree to 5= strongly agree) to submit their responses.

**Sexual satisfaction.** The New Sexual Satisfaction Scale (NSSS, Štulhofer, Buško, & Brouillard, 2010) (see Appendix D) is a composite measure of sexual satisfaction. The scale was developed based on five different dimensions that address sexual behavior. These dimensions include sexual sensations, sexual awareness and focus, sexual exchange, emotional closeness, and sexual activity. The scale construction was completed online obtaining a sample of over 2,000 participants internationally ages 18 to 55 (Štulhofer et al., 2010). This likert-type scale of 20 items consisted of questions such as "My body's sexual functioning/my partner's sexual availability" with projected responses ranging from 1-5 (1 = not at all satisfied, 5 = extremely satisfied) on a likert scale. Final analysis concluded that the NSSS is a useful tool for assessing sexual satisfaction regardless of gender identity, sexual orientation, or relationship status. Reliability was high for NSSS with a reported Cronbach's alpha of 0.94-0.96 (Štulhofer et al., 2010).

## **Data Analyses**

The demographic questionnaire provided insight in describing the samples' various intersectional identities. The inclusion criteria questions indicated the samples' gender identity and considered to be trans masculine with either having a binary or non-binary identity. The TGS (Kozee et al., 2012) was used to determine the level of comfort that trans people feel with their gender identity and external appearance. The total scale score was found by averaging the responses of the 12 items. The higher the score, the greater comfort with gender identity and external appearance. The Affirmative Sexual Partner Scale measured the sexual partner's role in affirming the gender identity of the trans masculine participant. The instrument identifies six factors that contribute to being an affirmative sexual partner. Responses from all 15 questions were combined, with a higher score indicating a more affirmative sexual partner. The NSSS (Štulhofer et al., 2010) was used to determine the level of sexual satisfaction through multiple domains of sexual behavior that included sexual sensations, sexual awareness and focus, sexual exchange, emotional closeness, and sexual activity. For the analysis of the NSSS, raw scores were used to indicate level of sexual satisfaction. Taken from a composite score of all 20 questions, the higher the score the greater the sexual satisfaction for that participant.

Statistical Package for the Social Science (SPSS) analyzed descriptive statistics and produced demographic data among the variables. The researcher conducted factor analysis to establish internal validity of scales (Keith, 2015). An exploratory factor analysis (EFA) was run on the Affirmative Sexual Partner Scale on all 15 items. EFA is used on a scale that has not been previously used. More specifically, EFA measures a smaller number of items, dividing them into constructs to decide which items to retain. The output included factor loadings and the correlations of the factors with each other. The researcher examined the results then decided

what the scales are measuring based on constructs they reflect through theory and previous research. A confirmatory factor analysis (CFA) was run on the New Sexual Satisfaction Scale and Gender Congruence Scale. The researcher then used previous research and theory to decide in advance the factors that underlie the measure. In other words, the researcher decided what the scales are measuring then examined the results. CFA reduced the measure into fewer items as the methodology worked by placing items that correlate highly on one factor while placing items that correlate at a low level together on different factors.

The first statistical analysis conducted in SPSS provided information on the first research question. Correlations were executed to explore the relationships between transgender congruence, affirmative sexual partners, and sexual satisfaction. The analyses explained the relationships and provided results to better understand the correlations between the variables. Next, moderation explored the relationships further with transgender congruence as the predictor variable and sexual satisfaction as the outcome variable. PROCESS (Hayes, 2012) in SPSS is used to address the analysis for moderation. The second model includes the moderation variable, affirmative sexual partners. A moderator specifies how the predictor variable is related to an outcome variable. In other words, when the moderator variable is introduced it explains and can change the direction of the relationship between the two variables. When increasing the moderator, it could reverse the effect of the predictor on the outcome. It was hypothesized that affirmative sexual partners would moderate the relationship between transgender congruence and sexual satisfaction.

## **Chapter Four**

### **Results**

In order to properly answer the research questions, a quantitative research methodology measured the relationships between the variables. In this chapter the first section describes the demographics of the participants in the study. The second section expands on the confirmatory and exploratory factor analyses run on the three measures: TCS, NSSS, and ASPS. The third section explores the correlations and means between the three measures: TCS, NSSS, and ASPS. The last section reports the moderation through PROCESS that explored the relationship between the three variables.

The goal of this study was to better understand the role of affirmative sexual partners and their effect on transgender congruence and sexual satisfaction. Langer (2014) suggested that the pain that transgender people experience in relation to their body may interfere with sexual satisfaction, however, research has shown that a sexual partner can aid in reducing distress around dysphoria during sex (Lindroth, Zeluf, Mannheimer, & Deogan, 2017). Few studies have explored the relationship between transgender congruence, sexual satisfaction, and affirmative sexual partners. Therefore, the focus of the present study was to determine any potential correlational relationships between transgender congruence, sexual satisfaction, and affirmative sexual partners. Online surveys were distributed to gather data using the following measures: The Transgender Congruence Scale, the New Sexual Satisfaction Scale, and the Affirmative Partner Scale.

As discussed in previous chapters, understanding the effects of transgender congruence and affirmative sexual partners on sexual satisfaction is important for clinicians who work with the trans community. The following questions helped formulate the study: (1) Is there a

relationship between transgender congruence, affirmative sexual partners, and sexual satisfaction? (2) Do affirmative sexual partners moderate the relationship between transgender congruence and sexual satisfaction?

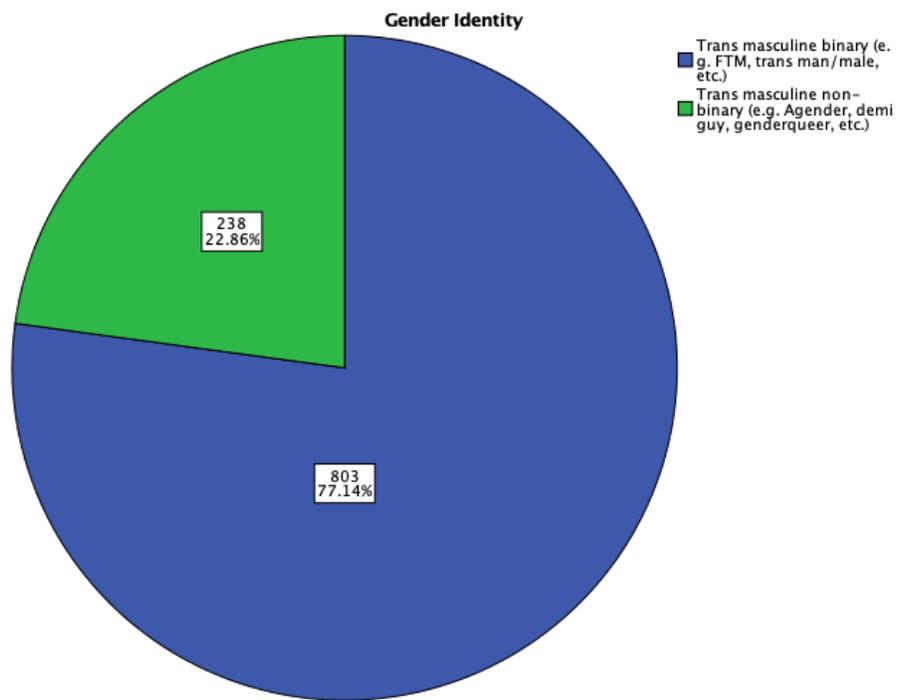
### **Demographics**

The final number of respondents that was gathered after the survey was accessible through Qualtrics for a period of two months included 1,298 trans masculine adults. Again, this was a tremendous gain from the targeted sample of 250 participants. The report generated through Qualtrics produced accurate findings with bar charts and statistical tables measuring the minimum, maximum, mean standard deviation, variance, and count for all 66 questions. The initial data analyses began with the Qualtrics report in order to review the text from ‘other (please specify)’ responses and the feedback question posed at the end of the survey. Following this, the researcher generated the data onto SPSS from Qualtrics in order to review all 1,298 participants for missing variables and unfinished surveys. Participant demographics were then calculated and organized into a pie chart and tables on Microsoft Word, using SPSS for accuracy checks. After assessing the dataset, cases with missing data were deleted, leaving the final sample size at 1,041 trans masculine adults in the sample (N= 1,041).

I maintained an intersectional approach by asking participants to provide information on demographics including gender identity, age, ethno-racial background, sexual identity, current location, and income. By consistently applying this intersectional lens, it allowed me to consider all identities and how the different identities are mutually influencing one another. Additional demographic questions were asked specifically about medical transition: hormone therapy (i.e., Testosterone), top surgery (i.e., chest reconstruction), and bottom surgery (i.e., Phalloplasty or

Metoidioplasty). The last two demographic questions assessed whether or not participants had engaged in therapy for assistance in gender transition and therapy for other life stressors.

With regards to gender identity, participants were asked whether they identified as trans masculine binary (e.g., FTM, trans man/male, etc.), trans masculine non-binary (e.g., agender, demi guy, genderqueer, etc.), or other. As seen in Figure 4.1, a large percentage of the sample identified as trans masculine binary, n=803 (77.14%), n=238 (22.86%) participants identified as trans masculine non-binary, and zero participants described their gender identity as ‘other.’



*Figure 4.1* Participants’ gender identity. Trans masculine binary participants (n=803) and trans masculine non-binary participants (n=238).

Table 4.1 provides data on age; the largest percentage of the participants were in the age range of 18-24 years old. Additionally, as the age range trickled down, zero participants were over the age of 64.

Table 4.1

*Age*

Age	Frequency	Percentage
18-24 years old	566	54.4%
25-34 years old	364	35.0%
35-44 years old	79	7.6%
45-54 years old	24	2.3%
55-64 years old	8	0.8%
Total	1,041	100%

Table 4.2 provides details about participants' ethno-racial backgrounds. Participants were given the option of identifying as Asian/Pacific Islander, Black or African American, Hispanic or Latino, Native American or American Indian, White, or Other. When participants chose 'other' option, with instructions to specify, 44 various responses of self-identified ethno-racial backgrounds emerged. The majority of the sample identified as White, n=890 (85.5%).

Table 4.2

*Ethno-Racial Background*

Ethno-Racial Background	Frequency	Percentage
Asian/Pacific Islander	31	3.0%
Black or African American	47	4.5%
Hispanic or Latino	94	9.0%
Native American or American Indian	30	2.9%
White	890	85.5%
Other	44	4.2%
African	1	0.1%
American/Caucasian/Cherokee	1	0.1%
Arab	2	0.2%
Armenian	1	0.1%
Ashkenazi	2	0.2%
Biracial	1	0.1%
Black and white	2	0.2%
Brazilian American	1	0.1%
Bulgarian	1	0.1%
Chicanx	1	0.1%
Dutch	1	0.1%
Dutch/Surinamese	1	0.1%
Ethnic Jew	1	0.1%
European-Canadian	1	0.1%
Half white half Filipino	1	0.1%
Hispanic and white	1	0.1%
Italian	1	0.1%
Jewish	5	0.5%



Metis	2	0.2%
Middle Eastern	4	0.4%
Mixed Ethnicity	3	0.3%
Mixed white, Asian/Pacific	1	0.1%
Islander and Native American		
Mixed: Caucasian and Indigenous Canadian (Qualipu Indian)	1	0.1%
Romanian	2	0.2%
Slavic	1	0.1%
Turkish/European	1	0.1%
White and Native American	1	0.1%
Total	1,041	100%

Participants' sexual identities varied, they were given the option to identify as asexual, bisexual, demisexual, gay, open/fluid, pansexual, queer, straight, and other. As seen in Table 4.3, 'queer' was reported having the highest frequency with n=235 (22.6%) responses. In addition, participants were given the option to describe their sexual identity as 'other' with instructions to specify this sexual identity, which produced 30 various responses of self-identified sexual identities.

Table 4.3

*Sexual Identity*

Sexual Identity	Frequency	Percentage
Asexual	22	2.1%
Bisexual	176	16.9%
Demisexual	32	3.1%
Gay	105	10.1%
Open/Fluid	35	3.4%
Pansexual	174	16.7%
Queer	235	22.6%
Straight	232	22.3%
Other	30	2.9%
Abrosexual	1	0.1%
Aromantic, mostly heterosexual, no cis men	1	0.1%
Biromantic with a straight tendency, and bisexual with an asexual tendency	1	0.1%
Bisexual and primarily attracted to women I sleep with straight men only	1	0.1%
Doesn't matter	1	0.1%
Exclusively attracted to women	1	0.1%
Gay as in I'm non-binary and only like women	1	0.1%

Greysexual	1	0.1%
Greysexual and androsexual	1	0.1%
Heteroflexible	3	0.3%
Homoflexible	2	0.2%
I use queer publicly, gay casually and around friends, but technically am bi/pan		0.1%
I'm non-binary and only sexually and romantically interested in women	1	0.1%
No label/only date women (cis and trans of course)	1	0.1%
Non-binary attracted to females	1	0.1%
Not sure	2	0.2%
Omnisexual	1	0.1%
Pansexual & Queer	2	0.2%
Pansexualflux	1	0.1%
Polysexual	1	0.1%
Still exploring	1	0.1%
Stone Demisexual	1	0.1%
Straight because I feel man and I'm attracted to girls	1	0.1%
Transman attracted to cisfemales	1	0.1%
Total	1,041	100%

Table 4.4 provides data on current location; participants were asked where they live and given the option to select geographical areas of the United States as defined by the United States Census Bureau into four regions (United States Census Bureau, 2013). The Midwest consists of Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, North Dakota, South Dakota, and Wisconsin. The Northeast- Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont. The South includes Arkansas, Alabama, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia. Lastly, the West- Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming. Additional locations included Puerto Rico and other U.S. territories or other, with directions to specify location. The largest number of participants were located in the United States, specifically the

largest frequency of participants located in the South region (n=242, 23.2%). The sample was warranted an international sample, with 206 participants choosing other, and specifying locations in Europe, Asia, South America, Russia, and Australia.

Table 4.4

*Location*

Current Location	Frequency	Percentage
Midwest	177	17.0%
Northeast	201	19.3%
South	242	23.2%
West	214	20.6%
Puerto Rico or other U.S. territories	1	0.1%
Other	206	19.8%
Australia	13	1.3%
Austria	1	0.1%
Belgium	1	0.1%
Brazil	1	0.1%
Canada	79	7.6%
Chile	1	0.1%
Colombia	1	0.1%
Czech Republic	1	0.1%
Denmark	1	0.1%
England	6	0.6%
Estonia	1	0.1%
Europe	6	0.6%
Faroe Islands	1	0.1%
Finland	2	0.2%
France	8	0.8%
Germany	12	1.2%
Homeless	2	0.2%
Ireland	2	0.2%
Italy	1	0.1%
Malaysia	1	0.1%
Mexico	1	0.1%
Netherlands	3	0.3%
New Zealand	2	0.2%
Northern Ireland	1	0.1%
Other	1	0.1%
Peru	1	0.1%
Poland	1	0.1%
Portugal	1	0.1%
Saudi Arabia	1	0.1%
Scotland	1	0.1%
South Africa	2	0.2%
Spain	1	0.2%
Student Abroad	1	0.1%
Sweden	3	0.3%
Switzerland	1	0.1%
Thailand	1	0.1%
United Kingdom	39	3.8%

Ukraine	1	0.1%
U.S. Other (frequently moving)	6	0.6%
Venezuela	1	0.1%
Total	1,041	100%

The personal annual income of participants is shown in Table 4.5. The most frequently reported category of personal annual income was less than \$10,000, n=330 (31.7%), and the second most frequent category reported was \$10,000 to less than \$20,000, n=256 (31.7%). Thus, over 60% of the sample reported having very low personal annual income.

Table 4.5

*Income*

Income	Frequency	Percentage
Less than \$10,000	330	31.7%
\$10,000 to less than \$20,000	256	24.6%
\$20,000 to less than \$30,000	134	12.9%
\$30,000 to less than \$40,000	113	10.9%
\$40,000 to less than \$50,000	64	6.1%
\$50,000 to less than \$60,000	41	3.9%
\$60,000 to less than \$80,000	56	5.4%
\$80,000 to less than \$100,000	22	2.1%
\$100,000 to less than \$150,000	18	1.7%
\$150,000 to less than \$200,000	4	0.4%
\$200,000 or more	3	0.3%
Total	1,041	100%

Three questions were posted to examine specifics around transition-related medical intervention for the sample. Participants had the option to respond yes, no, or do not desire to these three questions. The first question asked if participants had pursued hormone therapy (i.e., testosterone), the second top surgery (i.e., chest reconstruction), and third question bottom surgery (i.e., Phalloplasty or Metoidioplasty) as part of their transition journey. Table 4.6 presents this data; the highest frequency of participants reported taking testosterone, n=863 (82.9%), over half of participants reported having undergone top surgery, n=600 (57.6%), and only n=116 (11.1%) of participants reported having undergone bottom surgery.

Table 4.6

*Medical Transition*

Medical Transition	Frequency	Percentage
Testosterone		
Yes	863	82.9%
No	147	14.1%
Do not desire	31	3.0%
Top Surgery (i.e., Chest Reconstruction)		
Yes	600	57.6%
No	412	39.6%
Do not desire	29	2.8%
Bottom Surgery (i.e., Phalloplasty or Metoidioplasty)		
Yes	116	11.1%
No	559	53.7%
Do not desire	366	35.2%
Total	1,041	100%

The last two demographic variable questions included whether or not participants had attended therapy for assistance in gender transition and whether or not they attended therapy for other life stressors. Table 4.7 shows both a high percentage of participants attended therapy for assistance in gender transition, n=806 (77.43%) and for other life stressors, n=908 (87.22%).

Table 4.7

*Therapy Data*

Therapy	Frequency	Percent
Assistance in gender transition		
Yes	806	77.4%
No	235	22.6%
Therapy for other life stressors		
Yes	908	87.2%
No	133	12.8%
Total	1,041	100%

This study aimed to explore the participant’s most recent sexual partner’s demographics as well. The Affirmative Sexual Partner Scale asked questions pertaining to the most recent sexual partner. These questions included age (Table 4.8), ethno-racial background (Table 4.9),

gender identity (Table 4.10), sexual identity (Table 4.11), and the length of the sexual relationship (Table 4.12). For partner’s ethno-racial background, one participant described being with multiple partners of three different ethnicities in their specified response. Therefore, the total number of responses (n=1,043) is higher than the number of participants in the sample (N=1,041).

Table 4.8

*Recent Sexual Partner’s Age*

Recent Sexual Partner’s Age	Frequency	Percent
18-24 years old	501	48.1%
25-34 years old	374	35.9%
35-44 years old	113	10.9%
45-54 years old	35	3.4%
55-64 years old	17	1.6%
65-74 years old	0	0.0%
75+ years old	1	0.1%
Total	1,041	100%

Table 4.9

*Recent Sexual Partner’s Ethno-Racial Background*

Recent Sexual Partner’s Ethno-Racial Background	Frequency	Percent
Asian/Pacific Islander	44	4.2%
Black or African American	64	6.1%
Hispanic or Latino	117	11.2%
Native American or American Indian	34	3.3%
White	825	79.3%
Other	33	3.2%
African American & Hispanic	1	0.1%
Arab	2	0.2%
Bi-racial/mixed (Black & White)	7	0.7%
Black and Korean	1	0.1%
Brazilian	1	0.1%
Brazilian Dutch	1	0.1%
Canadian & First Nations	1	0.1%
Greek	1	0.1%
Greenlander	1	0.1%
Half Asian and Half White	1	0.1%
Indian	2	0.2%
Interracial	3	0.3%
Jewish	3	0.3%
Lebanese	1	0.1%
Middle Eastern	2	0.2%

Mixed Australian Indigenous/White		
Mixed-White and Middle Eastern	1	0.1%
Multiracial (white/Black/Latino)	1	0.1%
Persian/Iranian		
Portuguese	1	0.1%
Quebecois (French-Canadian-White)	1	0.1%
South Asian, raised in Europe	1	0.1%
White and Puerto Rican		
Total	1,043	100%

Table 4.10

*Recent Sexual Partner's Gender Identity*

Recent Sexual Partner's Gender Identity	Frequency	Percent
Cisgender male	278	26.7%
Cisgender female	490	47.1%
Trans man or trans masculine	92	8.8%
Trans woman or trans feminine	53	5.1%
Non-binary/genderqueer/ agender	104	10.0%
Other	24	2.3%
Non-binary trans woman	1	0.1%
Non-binary polyamorous	1	0.1%
Bisexual	1	0.1%
Ciswoman	1	0.1%
Doesn't believe in labels	1	0.1%
Female	2	0.2%
Gender nonconforming	1	0.1%
Genderfluid	2	0.2%
Genderfluid but assigned female at birth	1	0.1%
Intersex	1	0.1%
Intersex Man	1	0.1%
Lesbian	6	0.6%
None applicable	1	0.1%
Questioning	1	0.1%
Questioning, assigned male at birth	1	0.1%
Questioning, Feminine leaning	1	0.1%
DMAB	1	0.1%
Trans masculine non-binary	1	0.1%
Total	1,041	100%

Table 4.11

*Recent Sexual Partner's Sexual Identity*

Recent Sexual Partner's Sexual Identity	Frequency	Percent
Asexual	14	1.3%
Bisexual	276	26.5%
Demisexual	29	2.8%

Gay	150	14.4%
Open/fluid	57	5.5%
Pansexual	215	20.7%
Queer	107	10.3%
Straight/heterosexual	162	15.6%
Other	31	3.0%
Asexual-spectrum & bisexual	1	0.1%
Bisexual, mostly gay	1	0.1%
Both pansexual and asexual	1	0.1%
Bisexual/Pansexual	1	0.1%
Does not use labels	2	0.2%
Gay/asexual	1	0.1%
Homoflexible	2	0.2%
Lesbian	6	0.6%
Pansexual, queer, male leaning (gay af)	1	0.1%
Predominantly attracted to women but not exclusively	1	0.1%
Queer but doesn't like cis men	1	0.1%
Questioning	1	0.1%
Range from gay to bi/pan/queer	1	0.1%
Straight (but with me)	1	0.1%
They don't know, maybe demi?	2	0.2%
Trans/heterosexual	1	0.1%
Undecided	1	0.1%
We're in a 'straight' relationship but she still identifies as a 'lesbian'	1	0.1%
	6	0.6%
<b>Total</b>	<b>1,041</b>	<b>100%</b>

Table 4.12

*Length of Relationship with Recent Sexual Partner*

Length of Relational w/ Recent Sexual Partner	Frequency	Percent
Less than 6 months	224	48.1%
6 months to 2 years	341	32.8%
2 years to 5 years	299	28.7%
5 to 10 years	128	12.3%
10+ years	49	4.7%
<b>Total</b>	<b>1,041</b>	<b>100%</b>

The Affirmative Sexual Partner Scale reported specifics on preferred partner's sexual identities. Participants were instructed to specify responses if they selected 'somewhat agree' or 'strongly agree' to the question "I find it easier to have sexual experiences with partners of certain sexual identities over others." After one response was omitted that could not be



interpreted, n=241 (28.1%) participants responded with ‘somewhat agree’, and n=247 (28.8%) participants selected ‘strongly agree’.

Responses often described a gender identity that tied into sexual identities (e.g., gay trans men or straight cisgender women) therefore categories contain subcategories to specify identities. Many participants described more than one sexual identity; the total number of responses was n=857 (82.3%) participants. For the purpose of inclusion, all ‘please specify’ responses are reported in Table 4.13.

Table 4.13

*Preferred Partners’ Sexual Identities*

Preferred Partners’ Sexual Identities	Frequency	Percent
AFAB	2	0.2%
Non-binary	2	0.2%
Queer	1	0.1%
Trans	1	0.1%
Anyone who identifies within the lgbtqia+ community	10	1.2%
Asexual	6	0.7%
Grey	1	0.1%
Attracted to men	1	0.1%
Attracted to multiple genders	1	0.1%
Bisexual	204	23.8%
Cis	1	0.1%
Cisgender men	7	0.8%
Men	21	2.5%
Trans	1	0.1%
FTM	1	0.1%
Women/females	20	2.5%
Cis female/woman	5	0.6%
Cis men/males	5	0.6%
Demisexual	8	0.9%
Fluid	15	1.8%
Gay/homosexual	42	5.0%
Cisgender men	10	1.2%
Men/male	41	4.8%
Trans men/male/FTM	4	0.5%
Women	4	0.5%
Knew I was trans/trans familiar	1	0.1%
Women	1	0.1%
Lesbian	22	2.6%
Fem	1	0.1%
Woman	1	0.1%
MSM	1	0.1%
Non-binary/genderqueer	4	0.5%

Femme	1	0.1%
Not anyone only attracted to women	4	0.5%
Not straight/cishet/heterosexual	13	1.5%
Men	3	0.4%
Omnisexual	2	0.2%
Open	7	0.8%
Pansexual	167	19.5%
Cis	1	0.1%
Men	4	0.5%
Trans	1	0.1%
Women	6	0.7%
Polysexual	3	0.4%
Queer	95	11.1%
Cis men	1	0.1%
Cis women	1	0.1%
Men/male	7	0.8%
Women	8	0.9%
Straight/heterosexual	24	2.8%
Cisgender women/female	15	1.8%
Men/male	3	0.4%
Women/female	25	2.9%
Trans/transgender	8	0.9%
Female/women	3	0.4%
FTM	1	0.1%
Guys/Men	3	0.4%
Masculine	6	0.7%
Total	857	100%

The Affirmative Sexual Partner Scale explored sexual identities that participants were less likely to engage with sexually. The following question was asked, “I am less likely to engage in sexual activity with partner of certain sexual identities” with instruction to specify if they selected ‘somewhat agree’ or ‘strongly agree.’ After one response was omitted that could not be interpreted, n=177 (26.6%) participants selected ‘somewhat agree.’ In the same way, after removing one response that could not be interpreted, n=297, (44.6%) responses were recorded for ‘strongly agree.’

Participants’ responses included specifics around gender identity and other selection criteria (e.g., cisgender gay male, those of whom their sexual orientation opposes my gender identity, anyone not a gay man, etc.). Additionally, responses from each participant often included more than one sexual identity. All responses were accounted for in the demographic

statistics and contain subcategories of gender identities that related to specific sexual identities.

The inclusive responses of n=666, (64.0%) participants are reported in Table 4.14.

Table 4.14

*Least Likely Partners' Sexual Identity*

Least Likely Partners' Sexual Identity	Frequency	Percent
Anyone not a cisgender heterosexual female	3	0.5%
Anyone not a gay man	1	0.2%
Anyone not masculine	1	0.2%
Anyone not queer	1	0.2%
Asexual/Aromantic	5	0.8%
Bicurious	1	0.2%
Bisexual	14	2.1%
Female/woman	3	0.5%
Man/male	7	1.1%
Cisgender	2	0.2%
Male/man	25	3.8%
Women/female	7	1.1%
Curious/Discreet	1	0.2%
Demisexual	1	0.2%
Female attracted/only into women	12	1.8%
Trans chasers	1	0.2%
Gay/homosexual	36	5.4%
Cisgender	1	0.2%
Cisgender female/woman	2	0.3%
Cisgender men	8	1.2%
Female/woman	10	1.5%
Men/males	29	4.4%
Trans woman	1	0.2%
Genderqueer	1	0.2%
Heteroflexible	2	0.3%
Homoflexible	1	0.2%
Identity that excludes attraction to men	4	0.6%
Lesbian	89	13.4%
Bisexual	1	0.2%
Cisgender	2	0.3%
Sapphic	2	0.3%
Trans phobic	2	0.3%
Wlw	1	0.2%
Woman/female	25	3.4%
Male body part person	1	0.2%
Male/men	17	2.6%
Masculine	4	0.6%
Monosexual		
Gay	1	0.2%
Straight	1	0.2%
Non-binary	3	0.5%
Omnisexual	1	0.2%

Pansexual	14	2.1%
Poly/engage with other partners	1	0.2%
Queer	3	0.5%
Cis men	1	0.2%
Men	1	0.2%
Risk sexual abuse or emotional manipulation that can occur without proper levels of queer understanding and rigid binary systems	1	0.2%
Straight/heterosexual	146	21.9%
Cisgender	6	0.9%
Cisgender male/men	13	2.0%
Cisgender women/female	11	1.7%
Men/male	84	12.6%
Curious	1	0.2%
Chase trans men	1	0.2%
Trans men	1	0.2%
Trans woman	1	0.2%
Woman/female	30	4.5%
Sexual identity opposes my gender identity	1	0.2%
Someone only attracted to cis female bodies/genitals	3	0.5%
Trans/Transgender	2	0.3%
Ftm	1	0.2%
Man	3	0.5%
Masculine	1	0.2%
Mtf	1	0.2%
Women/female	5	0.8%
Woman/female/femme	3	0.5%
<b>Total</b>	<b>666</b>	<b>100%</b>

## Factor Analysis

Factor analyses are one of the most commonly used statistical procedures in the evaluation of multi-item psychological measures for investigating relationships between observed and latent variables (Byrne, 2016; Floyd & Widaman, 1995). Factor analysis is a method of establishing internal validity and reliability of scales (Kline, 2013). Factor analysis has two common approaches used to assess psychological measures, exploratory factor analysis and confirmatory factor analysis (Newsom, 2017). Both these analyses are used in the current study to establish reliability of the prior measures and the newly developed measure. Deciding on which type of factor analysis to use depends on the research goal, constructs, and the type of measurement (Floyd & Widaman, 1995).

The overall goals of these analyses are to confirm, explain, or reduce the data when necessary. To begin with, exploratory factor analysis is used in the development of an instrument to either identify latent constructs or reduce data. The exploratory factor analysis is used to confirm a hypothesis generated from theory and assess the construct validity of the measure, “retaining the factors that account for significant amount of variance in the data” (Floyd & Widaman, 1995, p. 293). Following this, Floyd and Widaman (1995) add that confirmatory factor analysis “assesses goodness of fit based on the variance remaining after the factors are taken into account” (p.293) and used in later stages to validate the existing measure, assuring the instrument is a good fit for the data. Confirmatory factor analysis is discussed first, following the order of instruments administered in the survey, with appropriate data analyses.

### **Confirmatory Factor Analyses**

Confirmatory factor analysis (CFA) begins with a hypothesis about how many factors there are, and which items load on each factor; these factors are obtained from the exploratory factor analysis (Newsom, 2017). In order to use CFA, the researcher must have knowledge on the overall variable structure derived from theory and prior research. This is conducted in studies in which measures have been developed and exploratory factor analysis were already conducted to determine which factors to retain. Therefore, the construct validity is supported if the confirmatory factor analysis demonstrates that the scale is consistent with the constructs developed through exploratory factor analysis (Floyd & Widaman, 1995).

Confirmatory factor analysis conducts a test to investigate how well the hypothesized factor structure fits the data (Newsom, 2017). This is also known as the goodness of fit and can be assessed in multiple ways. The goal of confirmatory factor analysis is to find a significant result, tested within the chi-square goodness-of-fit test, which evaluates the covariates among

measured variables not accounted for; indicating adequate fit to the data (Floyd & Widaman, 1995). Newsom (2017) explained, “the model fit is derived from comparing the correlations among the items to the correlations expected” (p.27). Additionally, Browne and Cudeck (1993) stated that because structural models are approximations, models should not fit perfectly, rather fit close to the data.

Common fit indices used to interpret results (Byrne, 2016) include:

- Chi-square ( $\chi^2$ ), lower values indicate better fit
- Root Mean Square Error of Approximation (RMSEA), lower values indicate better fit (<.06)
- Root Mean Square Residual (RMR), lower values indicate better fit (<.08)
- Comparative Fit Index (CFI), higher value indicates better fit (>.95)
- Tucker-Lewis Index (TLI), higher value indicates better fit (>.95)

AMOS is the statistical tool used to run confirmatory factor analysis, which is a programming extension from SPSS that was developed by James Arbuckle (Arbuckle, 2011). AMOS provides graphical program output in order to test models for goodness-of-fit.

**Transgender Congruence Scale.** The Transgender Congruence Scale was the first instrument analyzed for goodness-of-fit. Kozee et al. (2012) developed this measure that includes 12 items with two subscales derived from an exploratory factor analysis on the items. The scale measures the way in which transgender individuals feel comfortable with their gender identity and external appearance. The scale is measured from 0-60; a lower score indicates higher body dysphoria and negative feelings around their identity, with a higher score indicating more positive feelings around their gender identity and external appearance. In the original study, Kozee et al. (2012) conducted two analyses, the first analysis revealed two subscales:

Appearance Congruence and Gender Identity Acceptance. The second study confirmed the factor structure as psychometrically sound, connected to transgender identity, and produced the final 12-item Transgender Congruence Scale.

Kozee et al. (2012) conducted a confirmatory factor analysis on the measure, using the common fit indices to interpret the results. Their model provided an adequate fit to the data,  $\chi^2(53) = 167.41$ ,  $p < .001$ , CFI = .96, RMR = .04, RMSEA = .08. In this study, indices of CFA revealed that the model was a good fit,  $\chi^2(53) = 695.10$ ,  $p < .001$ , CFI = .90, RMR = .09, RMSEA = .10, TLI = .92. The modification indices revealed that item five- "My physical body represents my gender identity and item six- "The way my body currently looks does not represent my gender identity" had a value of 119.01. These high modification indices indicate that the overall fit would be improved if these items were removed. However, after examining the correlations ( $r = .07$ ), the researcher decided to retain both items, as the original study provided an adequate-good fit with all 12 items. Cronbach's Alpha for the Appearance Congruence subscale was .92; the Gender Identity Acceptance subscale was .70; and the total Transgender Congruence Scale was .89 indicating good internal reliability.

**New Sexual Satisfaction Scale.** To explore the factorial structure of the New Sexual Satisfaction Scale, previous literature tied to theory was used to decide in advance which factors underlie the measure. Štulhofer et al. (2010) in their development of the scale, performed analyses that reduced many items into a smaller measure consisting of two subscales, Ego-centered and Partner-centered. In the current study, I replicated a two-factor hierarchical model using confirmatory factor analysis. Model specification resulted in a poor fit ( $\chi^2(135) = 1884.7$ ,  $p < .001$ , CFI = .86, RMR = .17, RMSEA = .11, TLI = .84). However, because of the high reliability of the scale, and prior analysis run in earlier studies, all items were retained.

Reliability was tested in the current study, with a Cronbach's Alpha of .92 for the Ego subscale and .91 for the Partner subscale. The total New Satisfaction Scale reported a Cronbach's Alpha of .94.

### **Exploratory Factor Analysis**

The exploratory side of factor analysis has two main uses, to explain or reduce data (Floyd & Widaman, 1995). The first use is to identify the dimensions that arise within the measure. The factor analysis produces a specific number of factors, which are then named, representing theoretical constructs within the domain. These dimensions then serve as subscales within the measure. Overall, according to Floyd and Widaman (1995) an exploratory factor analysis is deemed exploratory because the researcher does not have prior expectations of what subscales, also known as latent variables, arise from analysis. In the second use, data reduction is used to eliminate items that fail to load on a factor. By reducing the large set of items, a smaller set increases the reliability of the measure. The process of exploratory factor analysis is to extract components that account for the maximum variance in the observed variables, then following this, components are extracted until all of the variance is accounted for. Interpreting the results of an exploratory factor analysis includes reporting factor loadings that are above .40 as significant (Floyd & Widaman, 1995).

**Affirmative Sexual Partner Scale.** To explore the structure of the Affirmative Sexual Partner Scale, a measure that has not been previously used, all items were subject to an exploratory factor analysis to measure the items into dimensions. The development of this scale was informed by qualitative interviews with trans masculine participants by Martin and Coolhart (2019). The responses by participants provided feedback in relation to body dysphoria, sexual



satisfaction, and sexual partners. The development of the scale was produced by topics and answers from these participants.

**Validity.** The original questions asked in the survey were assessed for face validity. It was concluded that seven items need to be removed for the measure to accurately capture partner affirmation. To begin with, item 9- “Communication about what feels comfortable or uncomfortable sexually happens on a regular basis” was removed as item 7 asked the same question about communication, “My sexual partner and I communicate about my sexual needs.” Next, questions 10-15 were removed because they inquired about the trans masculine person’s individual experience, not their experience of their sexual partner. These multiple questions were individual processes that did not directly address the interpersonal sexual relationship, which was the intent of this measurement. After going back to the data and examining the origin of these questions, it was found that these questions did not properly measure affirmation: Item 10- “I allow my sexual partner to touch dysphoric parts of my body in order to satisfy them,” 11- “Sometimes even if I am not in the mood, I engage in sexual activity to please my partner, 12- “I find it easier to have sexual experiences with partners of certain sexual orientations over others,” and 13- “I am less likely to engage in sexual activity with partners of certain sexual identities.” Item 14- “I worry what my sexual partner will think about my gender identity during sex” and item 15- “I withhold discussing my sexual needs.” After exploring these items at face value, removing the items was the best decision because they did not match the variable in question and the deletions increased reliability scores.

**Exploratory factor analysis.** Common approaches used in AMOS for confirmatory factor analyses were selected. These methods included estimating the communalities and maximum likelihood to maximize the differences between factors. Lastly, Promax was the

method of factor rotation selected, which is recommended for large data sets, allowing factor loadings to be more clearly interpreted (Osborne, Costello, & Kellow, 2008). This process was reported within exploratory factor analysis to decide which items to retain within the Affirmative Sexual Partner Scale. Output includes factor loadings and the correlations of the factors. The criteria for retaining factors included following Kaiser's criterion of eigenvalues greater than 1.0 (Kaiser, 1960). Following analysis, the results were examined and determined specifically what the scales measured.

**Factors.** Names for the factors were based on constructs they reflect through theory and previous research. Two tests were conducted in order to tell how well suited the data are for factory analysis. The Kaiser-Meyer-Olkin measure (Cerny & Kaiser, 1977) verified the sampling adequacy to move forward with the analysis,  $KMO = .873$ ; values between 0.8 and 1 indicate the sampling is adequate. Bartlett's test of sphericity  $X^2(28) = 5217.997, p < .001$ , informed significance and that factor analysis can be run with the measure. Using Kaiser's criterion of eigenvalues greater than 1.0, the results indicated that a two-factor solution would be the best solution for the data with a cumulative variance of 72.02%, which was confirmed by the scree plot (Floyd & Widaman, 1995). The maximum likelihood factor analysis had a cut-off point of .50 due to large sample size and are presented in bold in Table 4.14.

Initially, two factors were presented from the exploratory factor analysis. The first factor included all items, one to eight: Safety, connection, attraction, support, male view, feedback, communicate, check ins. This factor has an eigenvalue of 4.73 and accounts for 59.15% of the variance. The second factor included items seven and eight: Check ins and communicate, with an eigenvalue of 1.03 and accounts for 12.87% of the variance.

It is important to report all factor loadings to provide accurate information, therefore all factor loadings are provided. One item loaded onto both factors (.51)- “communicate.” However, since the sample size was large and that item barely loaded onto factor two, with more items available within the scale, the threshold for loading factors was increased to above .50. As shown in Table 4.15, the items are highlighted in bold, with higher loadings on factor one. With results indicating only one factor, this suggests that all items fit onto a single theoretical construct. In this case, affirmation, which is the operational definition of the one-dimension scale. This new Affirmative Partner Scale was computed in SPSS and used for all data analyses moving forward.

Table 4.15

*Exploratory Factor Analysis of the Affirmative Sexual Partner Scale*

Items	Factor		Dimension
	1	2	
Variance %	59.15%	12.87%	Affirmation
Safety	<b>.82</b>	-.07	
Connection	<b>.73</b>	-.01	
Attraction	<b>.68</b>	.34	
Support	<b>.83</b>	-.38	
Male view	<b>.76</b>	-.45	
Feedback	<b>.85</b>	-.29	
Communicate	<b>.73</b>	.51	
Check ins	<b>.75</b>	.47	

**Confirmatory Factor Analysis of Affirmative Sexual Partner Scale**

Following the exploratory factor analysis of the Affirmative Sexual Partner Scale, a confirmatory factor analysis was conducted. The factorial structure of the Affirmative Sexual Partner Scale has not been explored in prior studies, with development beginning in this study. A confirmatory factor analysis was run with the original scale of 15 items. The CFA with all 15

items was run without any subscales since the EFA included only the eight items that did not result in any subscales. The CFA resulted in the following fit indices:  $\chi^2(80) = 651.01$ ,  $p < .001$ , CFI = .92, SRMR = .07, RMSEA = .08, TLI = .90.

The 8-item scale that produced one subscale from the retained factors in the exploratory factor analysis was explored through a two-factor hierarchical model confirmatory factor analysis. The CFA resulted in the following fit indices:  $\chi^2(20) = 1061.43$ ,  $p < .001$ , CFI = .80, SRMR = .125, RMSEA = .224, TLI = .72. According to the common fit indices used to interpret results (Byrne, 2016), this model is not a great fit as all fit indices are outside of the parameters. However, this is useful information, indicating that the scale needs to be manipulated in the future to provide better fit to the population.

**Reliability.** Reliability of the scale increased, with the original Affirmative Sexual Partner Scale having a Cronbach's Alpha of .59. The revised Affirmative Sexual Partner Scale had higher reliability with a Cronbach's Alpha of .75.

## Means

The mean scores for the three scales are displayed in Table 4.16. The means were compared with standards set by the developers of the measures (Kozee et al., 2012; Martin & Coolhart, 2019; Štulhofer et al., 2010). All three measures: Affirmative Sexual Partner Scale, New Sexual Satisfaction Scale, and Transgender Congruence Scale indicated that the higher the response, the more positive experience of partners being affirmative, sexual satisfaction, and higher transgender congruence. The Transgender Congruence Scale ( $M=39.52$ ,  $SD=10.63$ ) indicated that more participants experienced low transgender congruence. The mean scores for the New Sexual Satisfaction Scale were slightly above average ( $M=60.72$ ,  $SD=15.84$ ) indicating average sexual satisfaction. Lastly, the Affirmative Sexual Partner Scale indicated a low

response for affirmative sexual partners (M=44.76, SD=8.99). Additionally, means and standard deviations for each subscale (see Appendix C for subscales) within the measures are provided in Table 4.17.

Table 4.16

*Mean Scores for Measures*

Scale	N	M	SD
TCS	1041	39.52	10.63
NSSS	1041	60.72	15.84
ASPS	1041	44.76	8.99

Table 4.17

*Mean Scores for Subscales*

Scale	N	M	SD
ASPS	1041	34.50	6.54
AppCon	1041	27.50	9.76
GenID	1041	12.02	2.73
Ego	1041	33.53	9.43
Partner	1041	27.19	8.02

**Research Question One**

This study had two main research questions. The first research question: *Is there a relationship between transgender congruence, affirmative sexual partners, and sexual satisfaction?* Research question one posed whether there was a relationship between transgender congruence, affirmative sexual partners, and sexual satisfaction, posing two hypotheses. In order to address the first research question, analyses including correlations were run to explore the relationship between the main variables.

**Hypothesis one.** Transgender congruence will be significantly and positively related to sexual satisfaction.

Transgender congruence was found to have a low significant, yet positive correlation to sexual satisfaction ( $r=.275, p<.000$ ). The low correlation made testing for the variables positive in the sense that specific variables show group differences and higher means within the sample. Additionally, as transgender congruence had a low correlation to sexual satisfaction, affirmative sexual partners also had a low, positive correlation to transgender congruence ( $r=.253, p<.000$ ). As this study revealed, transgender congruence was found to have significant yet low correlations with any of the other variables. Hypothesis one can be confirmed which suggests a separate experience for transgender congruence, that does not interact significantly between affirmative sexual partners and sexual satisfaction. Following the results of the correlations, in order to explore if there is within group differences for transgender congruence in the sample, post hoc ANOVA were conducted; presented later in the 'Post hoc group differences' section.

**Hypothesis Two.** Affirmative sexual partners will be significantly and positively related to sexual satisfaction.

As indicated above, the correlations of the measures indicate that there is a moderate approaching high, positive, correlation between Affirmative Sexual Partners and Sexual Satisfaction ( $r=.651, p<.000$ ). This correlation indicates that as the level of affirmative sexual partners increased, sexual satisfaction increased. Therefore, it is possible to accept Hypothesis 2, since there is a positive relationship between the two variables.

## **Correlations**

The study examined potential correlational relationships between transgender congruence. To respond to the first research question, *Is there a relationship between transgender congruence, affirmative sexual partners, and sexual satisfaction?* A Pearson correlation coefficient was used to assess the relationship between the scores of the TCS and

NSSS. *Pearson's product moment correlation*, more commonly known as *Pearson's r* is the measure of association used in this study. The closer *r* is to 1, the stronger the relationship between variables. Correlations are tested between main variables in the study, shown in Table 4.18. Transgender Congruence (TCS) had a low, positive, significant correlation to Sexual Satisfaction (NSSS)  $r=.275$ ,  $p<.001$ . Therefore, as transgender congruence increased, participants' sexual satisfaction slightly increased. There was also a low, positive, significant correlation between Transgender Congruence and Affirmative Sexual Partners (ASPS)  $r=.253$ ,  $p<.001$ . As the affirmation from sexual partners increased, transgender congruence also increased slightly. Lastly, there was a moderate approaching high, positive, significant correlation between Affirmative Sexual Partners (ASPS) and Sexual Satisfaction (SSS)  $r=.651$ ,  $p<.001$ . Therefore, as the sexual partner's level of affirmation increased, sexual satisfaction increased.

Table 4.18

*Correlations Between Measures*

		<b>Correlations</b>		
		ASPS	Transgender_ Congruence_ Scale	Sexual_ Satisfaction_ Scale
ASPS	Pearson Correlation	1	.253**	.651**
	Sig. (2-tailed)		.000	.000
	N	1041	1041	1041
Transgender_Congruence _Scale	Pearson Correlation	.253**	1	.275**
	Sig. (2-tailed)	.000		.000
	N	1041	1041	1041
Sexual_Satisfaction_ Scale	Pearson Correlation	.651**	.275**	1
	Sig. (2-tailed)	.000	.000	
	N	1041	1041	1041

\*\* . Correlation is significant at the 0.01 level (2-tailed).

Additionally, it was important to examine the correlations between the subscales for each measure. These correlations are shown in Table 4.19. The subscales were computed in SPSS to reflect all subscales for each measure. Beginning with the Transgender Congruence Scale, questions one to nine were included on the Appearance Congruence Subscale and questions ten to twelve were included on the Gender Identity Acceptance Subscale. The New Sexual Satisfaction Scale included the Ego Subscale, consisting of questions one to ten and the Partner Subscale including questions eleven through eighteen. Lastly, correlations are shown for the Affirmative Sexual Partner Scale, which included one scale consisting of items one through eight.

Within the subscale correlations there are three strong significant correlations worth reporting (highlighted in bold in Table 4.19). First, there was a strong positive correlation between the New Sexual Satisfaction Ego Subscale and the Affirmative Sexual Partner Scale ( $r=.562, p<.001$ ). Next, there was a strong positive correlation between the New Sexual Satisfaction Partner Subscale and the Affirmative Sexual Partner Scale ( $r=.626, p<.001$ ). Lastly, there was a strong positive correlation between the New Sexual Satisfaction Ego Subscale and the New Sexual Satisfaction Partner Subscale ( $r=.646, p<.001$ ). The correlations are a lot stronger with the New Sexual Satisfaction Partner Subscale versus the entire scale. Moving forward, this subscale could be used for more advanced analyses when exploring partnered sexual relationships.

Table 4.19

*Correlations Between Subscales*

		Correlations				
		ASPS	AppConSub	GenIDSub	EgoSub	PartnerSub
ASPS	Pearson Correlation	1	.208**	.240**	<b>.562**</b>	<b>.626**</b>
	Sig. (2-tailed)		.000	.000	.000	.000



	N	1041	1041	1041	1041	1041
AppConSub	Pearson Correlation	.208**	1	.194**	.272**	.136**
	Sig. (2-tailed)	.000		.000	.000	.000
	N	1041	1041	1041	1041	1041
GenIDSub	Pearson Correlation	.240**	.194**	1	.240**	.201**
	Sig. (2-tailed)	.000	.000		.000	.000
	N	1041	1041	1041	1041	1041
EgoSub	Pearson Correlation	<b>.562**</b>	.272**	.240**	1	<b>.646**</b>
	Sig. (2-tailed)	.000	.000	.000		.000
	N	1041	1041	1041	1041	1041
PartnerSub	Pearson Correlation	<b>.626**</b>	.136**	.201**	<b>.646**</b>	1
	Sig. (2-tailed)	.000	.000	.000	.000	
	N	1041	1041	1041	1041	1041

\*\* . Correlation is significant at the 0.01 level (2-tailed).

## Research Question Two

Research question two: *Do affirmative sexual partners moderate the relationship between transgender congruence and sexual satisfaction?* This question proposes one hypothesis, answering whether affirmative sexual partners moderate the relationship between transgender congruence and sexual satisfaction. Moderation analyses were run with PROCESS through SPSS, which examined the interaction between variables. PROCESS was developed by Hayes (2012) as an analytic tool for observed variables through moderation and mediation. PROCESS is a more simplistic add on in SPSS that tests variable interactions. PROCESS examines the relationship between *X* (independent variable) and *Y* (outcome variable) with *W* (moderator variable). Depending on how the study is conducted, the variable functions as either a moderator or mediator.

Mediation analysis is often used to test “how” or “why” an independent variable (IV) impacts the dependent variable (DV). Moderation analysis is used when one is interested in finding out if the effect of a variable on the outcome depends on a third variable (Hayes, 2012).

Moderation often answers the question “when” with the goal of analysis to determine whether the effect of  $X$  on  $Y$  depends on  $W$  (Hayes, 2012). In other words, moderation uses the variable to assess the strength of the relationship. Moderation implies an interaction effect, where the moderating variable changes the relationship between two variables. The relationship between the variables often depends on the interaction of the moderator (Hayes, 2018).

PROCESS is preferred over Structural Equation Modeling (SEM) because PROCESS can provide results with observed variables having one moderator without having to draw a path diagram. Models are preprogrammed into PROCESS based on the model to be estimated and simplified through moderation (Hayes, Montoya, & Rockwood, 2017). According to Hayes et al. (2017) PROCESS then automatically estimates the standards errors, confidence intervals, path coefficients, and t- and p-values. For models such as the one used in this study, with only moderation, SPSS is programed to estimate the model based on bootstrapping. Output is generated behind the scenes that would not be assessable or extremely complex with other programming.

In order to confirm a third variable making a moderation effect on the relationship between the two variables, we must show that the nature of this relationship changes as the moderating variable changes. A moderation analysis seeks to determine whether the effect of  $X$  on  $Y$  depends on and can be predicted by the moderator variable (Hayes, 2018). A moderation variable could buffer the effect of the predictor (IV) on the outcome (DV). For example, in the current study, a successful moderation analysis would express that the effect of transgender congruence on sexual satisfaction depends on or is moderated by affirmative sexual partners. Moderation analysis was conducted to understand the relationship between transgender congruence, affirmative sexual partners, and sexual satisfaction. Moderation using PROCESS

was appropriate since the research question aimed to explore if moderation was occurring between the independent and outcome variables.

**Moderation of affirmative sexual partners between body dysphoria and sexual satisfaction.** In order to address research question two, moderation analysis using PROCESS (Hayes, 2012) was conducted to determine whether affirmative sexual partners were a moderator between transgender congruence and sexual satisfaction. Model one determined that transgender congruence significantly predicts sexual satisfaction. Then, by adding affirmative sexual partners as a moderator, affirmative sexual partners moderated the relationship between transgender congruence and sexual satisfaction. The moderator was tested for direct interaction and significantly moderated the relationship between the variables. The R-sq. for the initial model with transgender congruence and sexual satisfaction was .44 indicating a 44% variance.

There was no change with addition of affirmative sexual partners as moderator ( $R_2 = .001$ ). Thus, the final model with the moderator predicted 44% variance [ $R_2 = .44$ ,  $F(3, 1037) = 272.84$ ,  $p < .001$ ]. Additionally, the upper level confidence interval (ULCI) and lower level confidence interval (LLCI), which is used to assess significance with bootstrap method within PROCESS did not pass through zero for the interaction (LLCI- .0041/ULCI- .0249) signifying a significant finding. The conditional effects of the moderator showed that at low (0-20), moderate (21-40), and high (41-60) transgender congruence (TC) affirmative sexual partners significantly moderated the relationship between transgender congruence and sexual satisfaction. Therefore, affirmative sexual partners did serve as a moderator between transgender congruence and sexual satisfaction. Figure 4.2 illustrates the interaction effect is significant at low, moderate, and high rates. Examination of the interaction plot (Figure 4.2) showed an enhancing effect that as transgender congruence and affirmative sexual partners increased, sexual

satisfaction increased. Therefore, having an affirmative sexual partner increased sexual satisfaction for those with varying degrees of transgender congruence.

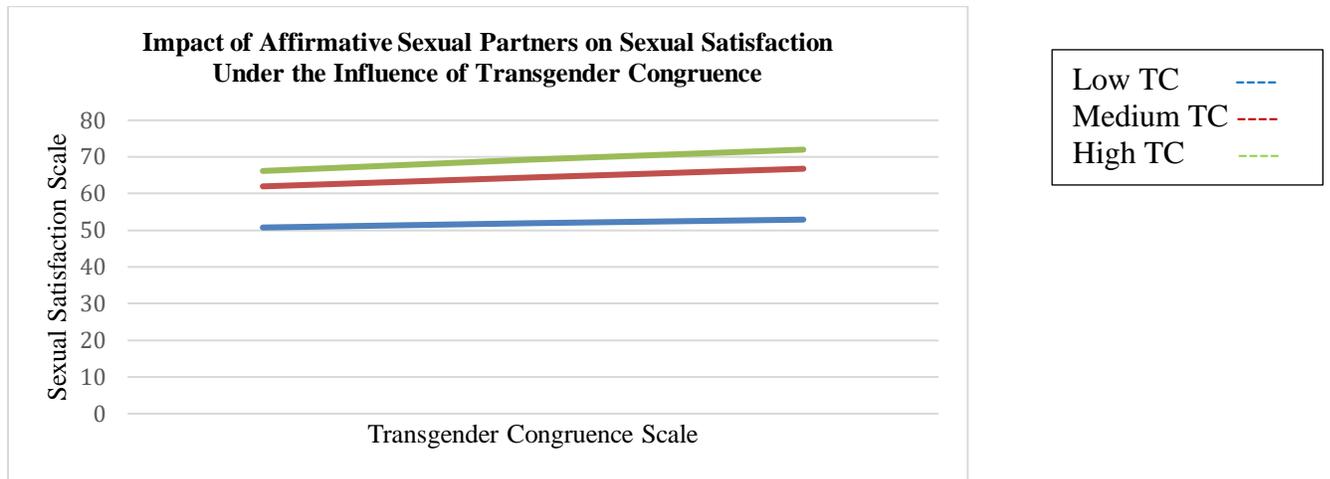


Figure 4.2. Moderation of affirmative sexual partners.

### Post Hoc Group Differences

A one-way Analysis of Variance (ANOVA) was conducted between groups to determine whether there were certain demographic groups who experienced a higher level of transgender congruence. ANOVA is used to determine if there are any statistically significant differences between the means of three or more independent groups (Leech, Barrett, & Morgan, 2015). A one-way ANOVA was performed with the Transgender Congruence Scale. However, before performing the ANOVA, assumptions were examined. Levene’s test was used to check for the equality of variance and *p* value. Skewness and kurtosis were examined to check for normality. Kim (2012) noted that sample sizes greater than 300, values larger than +2.0 for skew value and values larger than +7.0 for kurtosis are used as reference points to determine normality. If these assumptions are met, ANOVA can be performed.

The ANOVA test will determine if the results are significant but will not expand on the exact differences. Following the ANOVA, and if significant results are found, a post hoc is used

to determine the differences between the means. A post hoc is a specific comparison of means, the Tukey or Honest Significant Difference (HSD) test computes the means using a statistical distribution between the largest differences of means (Abdi & Williams, 2010). The Tukey test compares all possible means resulting in differences between groups.

Before running the statistical test, the assumptions of the ANOVA for the Transgender Congruence Scale were checked. Both the assumption of equal variance and normality of the ANOVA were met. ( $F(1,1039) = 4.09, p < .043$ ) (skewness =  $-.111$ , kurtosis =  $-.909$ ). Therefore, using transgender congruence as the dependent variable, a one-way ANOVA examined gender identity, age, sexual identity, and medical transition group differences. Previous research highlighted the positive impact of medical transition on increasing transgender congruence, but it was important to also highlight various identities that have not been explored.

**Gender identity.** An ANOVA explored the group differences between binary trans masculine and non-binary trans masculine participants on the Transgender Congruence Scale. ANOVA indicated there was a significant difference in transgender congruence between the two groups, ( $F(1, 1039) = 51.28, p < .001$ ). Given there was a significant interaction between the groups, the means table reported that binary trans masculine participants had higher gender identity acceptance and gender congruence ( $M=40.77, SD=10.54$ ) than non-binary trans masculine participants (Table 4.20) ( $M=35.29, SD=9.84$ ).

Table 4.20

*Gender Identity Post Hoc*

Gender Identity	N	Post Hoc
Trans Masculine Binary	803	( $M=40.77, SD=10.54$ )
Trans Masculine Non Binary	238	( $M=35.29, SD=9.84$ )
Total	1,041	( $M=39.52, SD=10.63$ )

**Age.** A one-way ANOVA was conducted to test for the effect of age on the Transgender Congruence Scale. This test revealed that age groups offered statistically significant differences ( $F(4, 1036) = 4.47, p < .001$ ). Given that there was a significant difference on the interaction effect of age and the Transgender Congruence Scale, a Tukey post hoc test was completed. This test was used because a statistically significant result was found; Tukey helps decide which specific groups are significantly different. The test revealed (Table 4.21), that 25-34 year olds had a significantly ( $p = .004$ ) higher mean ( $M = 40.87, SD = 10.95$ ) than 18-24 year olds ( $M = 38.34, SD = 10.34$ ). In other words, 25-34 year olds experienced less body dysphoria with higher body congruence and gender identity acceptance.

Table 4.21

*Age Post Hoc*

Gender Identity	N	Post Hoc
18-24 years old	566	( $M = 38.34, SD = 10.34$ )
25-34 years old	364	( $M = 40.87, SD = 10.95$ )
35-44 years old	79	( $M = 40.52, SD = 10.76$ )
45-54 years old	24	( $M = 43.88, SD = 7.85$ )
55-64 years old	8	( $M = 38.25, SD = 13.45$ )
Total	1,041	( $M = 39.52, SD = 10.63$ )

**Sexual identity.** The researcher conducted a one-way ANOVA on sexual identity, which revealed a significant difference between sexual identities for transgender congruence. This statistical test highlighted many statistical differences between sexual identities. The ANOVA indicated that sexual identity had significant differences between groups ( $F(8, 1032) = 6.75, p < .001$ ). More specifically, multiple statistical differences were found with those who identified as demisexual. Given the finding of statistical significance, a post hoc test was conducted. The post hoc revealed a significant difference ( $p = .001$ ) between those who identified as demisexual ( $M = 30.91, SD = 9.54$ ) and bisexual ( $M = 39.28, SD = 10.88$ ). Additionally, there was a significant

difference ( $p = .001$ ) between those who identified as demisexual ( $M = 30.91, SD = 9.541$ ) and gay ( $M = 41.91, SD = 10.60$ ). There was also a significant difference ( $p = .049$ ) between those who identified as demisexual ( $M = 30.91, SD = 9.541$ ) and pansexual ( $M = 37.14, SD = 10.57$ ). The post hoc revealed that those who identified as demisexual ( $M = 30.91, SD = 9.541$ ) and queer ( $M = 40.35, SD = 10.66$ ) had statistically significant differences ( $p = .001$ ). Lastly, for demisexual ( $M = 30.91, SD = 9.541$ ) participants, there was a statistically significant difference with straight/heterosexual participants ( $M = 41.84, SD = 9.77$ ), ( $p = .001$ ).

These findings indicate (Table 4.22) that those who identify as demisexual have lower body congruence and gender identity acceptance than five other sexual identities. There was a significant interaction ( $p = .015$ ) between those who identified as gay ( $M = 41.91, SD = 10.60$ ) and pansexual ( $M = 37.14, SD = 10.57$ ) indicating that those who identified as gay reported having lower transgender congruence than those who identified as pansexual. Lastly, there was a significant interaction ( $p = .001$ ) between straight/heterosexual participants ( $M=41.84, SD=9.77$ ) and pansexual ( $M = 37.14, SD = 10.57$ ) participants. Therefore, the highest reported transgender congruence was between straight and gay participants, while those who identified as demisexual had the lowest average of reported transgender congruence.

Table 4.22

*Sexual Identity Post Hoc*

Sexual Identity	N	Post Hoc
Asexual	22	(M=37.95, SD=10.66)
Bisexual	176	(M=39.28, SD=10.88)
Demisexual	32	(M=30.91, SD=9.54)
Gay	105	(M=41.61, SD=10.60)
Open/fluid	35	(M=37.11, SD=9.65)
Pansexual	174	(M=37.14, SD=10.57)
Queer	235	(M=40.35, SD=10.66)
Straight/heterosexual	232	(M=41.84, SD=9.77)
Other (please specify)	30	(M=36.10, SD=10.12)
Total	1,041	(M=39.52, SD=10.63)

**Medical transition.** In regard to medical transition, there were significant findings for all three survey questions that addressed testosterone, top surgery, and bottom surgery. First, a one-way ANOVA was tested on the effect between the Transgender Congruence Scale and testosterone (Table 4.23), with a significant difference reported ( $F(2, 1038) = 91.06, p < .001$ ). Post hoc tests revealed significant differences between those on testosterone and those not on testosterone ( $p = .001$ ) and that do not desire to take testosterone ( $p = .001$ ). Given these findings, a post hoc analysis was completed, findings indicated that those on testosterone ( $M = 41.38, SD = 10.12$ ) reported higher transgender congruence than those not taking testosterone ( $M = 30.19, SD = 8.24$ ) and do not desire to take testosterone ( $M = 31.97, SD = 7.61$ ).

Next, an ANOVA was conducted to examine the differences among top surgery and their level of transgender congruence (Table 4.23). There was a statistically significant difference between top surgery and the Transgender Congruence Scale ( $F(2, 1038) = 130.20, p < .001$ ). The significant difference led to a post hoc analysis that revealed significant differences between those who had top surgery and those who have not had top surgery ( $p = .001$ ) and those who had top surgery and do not desire to have top surgery ( $p = .006$ ). Those who answered 'yes' to top surgery indicated a higher experience of transgender congruence ( $M=43.56, SD=9.71$ ), while those that responded 'no' ( $M=33.75, SD=9.20$ ), and 'do not desire' ( $M=37.97, SD=9.83$ ) top surgery, indicated a lower frequency of transgender congruence.

Lastly, bottom surgery differences were explored through statistical tests (Table 4.23). A one-way ANOVA was conducted to test for the effect of bottom surgery and the Transgender Congruence Scale. There was a significant interaction between the bottom surgery responses and transgender congruence ( $F(2, 1038) = 13.99, p < .001$ ). Since a significant difference was found, post hoc analysis were completed. The post hoc analyses revealed statistically significant



differences between those who had bottom surgery and those who have not had bottom surgery ( $p = .001$ ) and between those who had bottom surgery and those who do not desire bottom surgery ( $p = .001$ ). Those who answered ‘yes’ to bottom surgery indicated a higher experience of transgender congruence ( $M=44.29, SD= 38.64$ ), while those who responded ‘no’ ( $M=38.64, SD=10.10$ ), and ‘do not desire’ ( $M=39.34, SD=11.19$ ) bottom surgery indicated a lower frequency of transgender congruence. The presence of variability in the dependent variable and independent variables may indicate a need to include above factors as control variables in moderation models in future studies.

Table 4.23

*Medical Transition Post Hoc*

Medical Transition	N	Post Hoc
Testosterone		
Yes	863	(M=41.38, SD=10.12)
No	147	(M=30.19, SD=8.24)
Do not desire	31	(M=31.97, SD=7.61)
Top Surgery		
Yes	600	(M=43.56, SD=9.71)
No	412	(M=33.75, SD=9.20)
Do not desire	29	(M=37.97, SD=9.83)
Bottom Surgery		
Yes	116	(M=44.29, SD=10.17)
No	559	(M=38.64, SD=10.10)
Do not desire	366	(M=39.34, SD=11.19)
Total	1,041	(M=39.52, SD=10.63)

**Summary**

To answer research question one, analyses revealed that the majority of the sample experienced low transgender congruence, meaning the participants experienced their body not representing their internal gender identity. Although transgender congruence was low, affirmative sexual partners were approaching average, with sexual satisfaction above average. As the correlations revealed, hypothesis one was accepted as transgender congruence was found to have a low, yet positive correlation with sexual satisfaction and affirmative sexual partners,

setting the stage to further explore subgroups. Hypothesis two was accepted as affirmative sexual partners were found to have a high, significantly strong correlation with sexual satisfaction. The second research question was tested using moderation analysis in order to understand the relationship between transgender congruence, sexual satisfaction, and affirmative sexual partners. Results indicate that transgender congruence was a significant predictor of sexual satisfaction. In addition, when adding the affirmative sexual partners as a moderator, the moderator was significant in the relationship between transgender congruence and sexual satisfaction. ANOVA and post hoc analyses revealed significant group differences between gender identity, age, sexual identity, and medical transition. The implications of these findings are discussed in the following chapter.

## **Chapter Five**

### **Discussion**

This chapter presents the demographic and data analyzes results of the study, followed by limitations, clinical implications, and future research. The purpose of this study was to better understand the experience of transgender congruence, sexual satisfaction, and affirmative sexual partners for trans masculine people. This was accomplished by administering 45 questions from the Transgender Congruence Scale, the New Sexual Satisfaction Scale, and the Affirmative Sexual Partner Scale. In addition to the three scales, 19 demographic questions for trans masculine participants and their recent sexual partner were administered. The survey was available through Qualtrics and reached an international platform including participants from North America, Asia, Europe, South America, Africa, and Australia. Those who identified as trans masculine were invited to participate in the research study by Facebook, Instagram, Reddit, mental health providers, and medical professionals. In total, 1,041 trans masculine identifying people participated in the research.

This study sought to answer two research questions regarding the experience of transgender congruence, sexual satisfaction, and affirmative sexual partners for trans masculine participants. The aim was to gather a better understanding of how transgender congruence influences sexual satisfaction and the role of affirmative sexual partners between the variables for trans masculine people of diverse sexual identities. The research questions were:

- Question 1: Is there a relationship between transgender congruence, affirmative sexual partners, and sexual satisfaction?
- Question 2: Do affirmative sexual partners moderate the relationship between transgender congruence, and sexual satisfaction?

## Methods Summary

This quantitative study was utilized to determine the relationship between sexual satisfaction, transgender congruence, and affirmative sexual partners. Transgender congruence remained the independent variable since many trans masculine people experience distress about their primary and secondary sex characteristics. The dependent variable included sexual satisfaction, which addressed satisfaction in their sex lives. The moderator was affirmative sexual partners, defined as current or past sexual partners. The study then expanded on the three variables, exploring their relationships through various statistical analyses.

The study was conducted in the Northeast United States and reached an international audience through the use of social media platforms and snowball sampling. The target population for this study was trans masculine adults who identified anywhere along the trans masculine spectrum while meeting the inclusion criteria of at least 18 years of age, assigned female sex at birth, and sexually active in the past or present with a partner. The sample was obtained through those within the population who completed the online survey, which was accessible for two months. Participants were instructed to utilize snowball sampling, by passing the survey link to friends who fit the inclusion criteria. In total 1,298 participants responded to the survey, with 1,041 total participants after removing missing values.

**Measures.** Three online questionnaires were utilized to answer the research questions. In addition, demographic questions addressed the trans masculine participant's characteristics, and also their most recent sexual partner's demographics. The first measure, the Transgender Congruence Scale (Kozee et al., 2012) was developed to assess the level of comfort a transgender person feels with their gender identity and external appearance. The instrument was used in a prior study to understand the correlation between life satisfaction and depression in

relation to a transgender identity (Velez et al., 2016). Next, the Affirmative Sexual Partner Scale, a newly developed measure, was used to explore affirmation of sexual partners. This measure was developed by referencing Martin and Coolhart's (2019) study that explored sexual satisfaction and sexual performance with trans masculine adults. Themes were derived from that study that addressed affirmation of the sexual partner through aspects of safety, connection, attraction, support, feedback, and communication. Overall the questions aimed to measure the sexual partner's role in affirming the gender identity of the trans masculine partner. Last, the New Sexual Satisfaction Scale was developed to assess sexual satisfaction for any gender or sexual identity (Štulhofer et al., 2010). This scale addressed five different dimensions of sexual satisfaction such as sexual sensation, sexual awareness and focus, sexual exchange, emotional closeness, and sexual activity.

**Analysis.** SPSS analyzed demographic data, explored means and correlations between the three measures, and post hoc ANOVA. An exploratory factor analysis on the Affirmative Sexual Partner Scale determined which items to retain in the measure. Following this, a confirmatory factor analysis utilized on all three measures determined which factors underlie the measure based on theory. Correlations and PROCESS answered both research questions, assessed the relationship between the variables, and tested for moderation. The findings from the participants' responses are discussed in detail, by research question, beginning with the demographics.

### **Demographic Summary**

The 1,041 participants had vastly different demographic characteristics. It was important to highlight these various identities as transgender research has neglected representation of other identities outside of white and straight in the past (Edelman & Zimman, 2014). Out of the 1,041

participants, 803 identified as binary trans masculine and 238 non-binary trans masculine. It was important to gather data from both binary and non-binary participants as experiences around identity vary. The age range of the participants trickled down, as the majority of participants (n=566) were ages 18-24 years old, with 25-34 year old's following shortly behind. This data possibly highlighted the generational experience with social media and the increasingly common age depictions of transgender people on social media. In addition, McInroy and Craig (2015) note that social media is the main platform where transgender people gain knowledge about their experience of transition related issues.

Ethnic-racial backgrounds of the participants were majority white, which unfortunately parallels a lot of previous literature not reaching more diverse racial differences. However, sexual identity proved to be more diverse, as queer was the prominent sexual identity selected among participants. Most notably, the study reached an international sample as participants identified their location all over the world. The greatest number of participants reported residing in the Southern United States. Given the historical context of the south in relation to the LGBT community, this finding is important to give representation. The majority of participants reporting having an income of less than \$10,000 followed by \$10,000 to less than \$20,000. Considering the majority age of the participants, they could currently be attending college or not yet secure financially in their careers.

**Medical transition.** An important demographic to explore and connect to transgender congruence, is medical transition. A high number of participants (n= 863) reported taking testosterone, while over half stated they had top surgery (n=600), however, only a few reported having bottom surgery (n=116). As shown in the data analyses, medical transition was pivotal to increasing transgender congruence and reducing body dysphoria. The last demographic question

asked was in regard to therapy, both for assistance in gender transition and other life stressors. It is important to note that 87.2% (n=908) of the participants reported attending therapy for life stressors and 77.4% (n=806) for assistance in gender transition. This important finding highlights the urgency for clinicians to be well versed in transgender affirmative care when addressing issues around sexuality. Currently, since gender confirmation surgeries require letters by mental health providers, trans people often seek therapeutic assistance. Clinicians can make space for sexuality by being educated on the impact of body dysphoria and transition on sexual performance. Specifically, it's beneficial to remain systemic and open to discussing the sexual partner(s)' influence on their sex life.

The sample was composed of international binary and non-binary trans masculine people from a variety of ethnic and racial backgrounds (N=1,041). Main findings from the demographics of the sample included:

- Binary (77.1%) and non-binary (22.9%)
- Primarily white (85.5%)
- Between the ages of 18-24 (54.4%)
- Diverse sexual identities, largest percentage queer (22.6%)
- Testosterone (82.9%)
- Top surgery (57.6%)
- Bottom surgery (11.1%)
- Attended therapy (87.2%)

**Recent sexual partner's identities.** The next set of demographic questions addressed the participants' most recent sexual partner's identities. The demographics for the sexual partners paralleled many of the participants' characteristics. The participants' noted the majority

of their sexual partner's age was 18-24 years old (n=501) and majority white (n=825). The highest frequencies of partner gender identities were cisgender females (n=490) and most recent sexual partner's sexual identity was bisexual (n=276). Overall, 48.1% percent of participant's responded that the relationship with their most recent sexual partner was less than six months. The short-term length of relationship can be interpreted as sexual partners for casual sex, new relationships, or short-term relationships.

The last demographic finding gathered was the trans masculine participant's preferred and least likely preferred sexual partner's sexual identity. The sexual identities that the participants preferred were bisexual (23.8%) with subgroups consisting of cisgender, cisgender men, men, trans men, and bisexual women. This is an important finding as a partner's sexual identity can often affirm the transgender person's gender identity. Additionally, a more fluid sexuality may relieve dysphoria and assist in creating higher sexual satisfaction for the trans masculine identified partner. These findings are important to highlight significant identities that participants preferred and least preferred to partner with. Key demographic findings:

- Participants' sexual partners were around the same age (48.1%)
- Majority white (79.3%)
- Sexual partner was a cisgender female (47.1%)
- Sexual partner was bisexual (26.5%)
- Preferred a bisexual sexual partner (23.8%)
- Least preferred a straight/heterosexual sexual partner (21.9%)

### **Findings by Research Question**

Two research questions were proposed for this study. The data analyses applied to the research questions were based on the most statistically appropriate method. For the first research



question, *Is there a relationship between transgender congruence, affirmative sexual partners, and sexual satisfaction?*, correlations were explored to determine the relationship. Additionally, to allow further exploration into group differences, a one-way ANOVA with necessary post hoc analyses was conducted. For research question two, *Do affirmative sexual partners moderate the relationship between transgender congruence and sexual satisfaction?*, moderation analysis through PROCESS was utilized. Important findings are discussed as they connect to previous literature and research.

**Research question one.** The first research question aimed to establish a relationship between transgender congruence, sexual satisfaction, and affirmative sexual partners. Overall this sample experienced a low rate of transgender congruence, the means from the data, specifically the Transgender Congruence Scale data revealed that the average response was low on a scale of 1-60 ( $M = 39.51$ ), indicating low body congruence and gender identity acceptance. As the DSM-V (APA, 2013) highlights, gender dysphoria is often present in those who identify as transgender. The gender identity itself does not create distress; rather the dysphoria accompanies the gender identity, creating immense suffering from bodily incongruence.

**Transgender congruence findings.** Multiple studies have contributed to understanding the connection between transgender congruence and various aspects of sexual experience. Doorduyn and Van Berlo (2014) found that body dysphoria hinders the satisfaction of sexual experiences. Although hormonal treatment can increase sexual satisfaction, De Cuypere et al. (2005) indicate that genitals often play the most prominent role in sexual satisfaction. Becker et al. (2018) noted that intense dysphoria often causes extreme feelings of sexual discomfort and shame. Further, the authors described the participants experiencing a higher rate of distress compared to those who did not identify as transgender. Nikkelen and Kreukels (2018) highlight

that sexual function is important to well-being, but many transgender people face challenges in sexual experiences related to their pleasure and body response. They concluded from their study that body satisfaction is positively related to all sexual behavior, including satisfaction. Being transgender is closely related to sexual identity and body image, as the definition of dysphoria is the distress with primary and secondary sex characteristics.

Means revealed that the participants reported a slightly above average ( $M=60.72$ ) score on the New Sexual Satisfaction Scale. It was hypothesized that the two variables would show a statistically significant relationship with a high correlation. The analysis revealed that the two variables are statistically significant, however, there is a low correlation between body dysphoria and sexual satisfaction ( $r=.275$ ,  $p<.001$ ). The current study's low correlation can be explained through previously mentioned literature. The most prominent area of dysphoria is often the genitals, with this being said, the sample in the current study reported low bottom surgery completion (11.1%). Therefore, it is possible that participants may have had lower sexual satisfaction if they are not yet their true physical selves. Additionally, there was also a low, positive, correlation between Affirmative Sexual Partners and Transgender Congruence ( $r=.253$ ,  $p<.001$ ). This indicates that transgender congruence, or meaning the body being congruent to internal gender identity, is often an individual bodily experience that at times cannot be altered by partners.

**ANOVA.** It is important to explore why transgender congruence did not have strong relationships with the other variables. From the researcher's clinical experience, transgender congruence and the dysphoria that follows is a stand-alone phenomenon that often occurs internally and externally. Dysphoria is often an individual experience that essentially does not have a cure; those who experience dysphoria may ultimately have an impaired body image

despite any medical interventions (Becker et al., 2018). Since previous literature highlighted a connection, it was important to explore additional aspects of body dysphoria with group differences through ANOVA. Key findings revealed through post hoc, worth noting:

- Non-binary participants reported experiencing lower transgender congruence
- 25-34 year olds reported the highest transgender congruence
- Demisexual participants had the lowest transgender congruence
- Testosterone, top surgery, and bottom surgery all significantly improved transgender congruence

The results indicate that identity impacts the experience of transgender congruence as both non-binary participants and those who identify as demisexual reported lower transgender congruence. Perhaps, those who identify as non-binary do not have a linear transition process nor have available resources to alleviate dysphoria.

Time into transition and age were factors in participants' experiences of dysphoria. Those ages 25-34 reported the highest transgender congruence. Considering the method of recruitment, most commonly this age range was found to occupy social media in the transition related groups utilized. Data collection was obtained in groups that were private and those that access these groups have to be trans masculine identified. In addition, I did not have access to groups of certain age ranges above 30, considering the privacy of these groups. Since these groups consisted of those in the beginning stages of pursuing or completed bottom surgery, transgender congruence could have been higher. My limited access based on my age and identity, limited the age range of participants. For example, older people with high congruence might not be on social media. Also, those that are younger commonly expressed still being on their parents' insurance, may be living with an unsupportive family, or financially may not have

the means to access medical transition at the current moment.

Findings around medical transition increasing transgender congruence are echoed throughout previous literature. Testosterone plays a key role in reducing dysphoria, Slabbekoorn, Van Goozen, Gooren, and Cohen-Kettenis (2001) highlight that testosterone produces many physical changes reducing dysphoria. Hormonal changes brought on by testosterone may also improve psychological symptoms, lessening the incongruence between the mind and body, reducing dysphoria overall (Colton Meier et al., 2011). In the same way, both top and bottom surgeries alleviate dysphoria, reducing anxiety and discomfort (Davis & Meier, 2014). The current study reiterated statistically significant findings with medical intervention increasing transgender congruence. Previously, De Cuypere et al. (2015) noted an increase in sexual response following GCS, which reduced dysphoria in their genitals, leading to greater sexual satisfaction. The findings also echo Davis and Meier (2014), Devor (2009), Bockting et al. (2016), and Green (2004), who all note that testosterone and GCS reduced distress and increased internal perception of self. Lastly, the current study reiterates findings by mental health clinicians as early as Harry Benjamin (1966), that medical transition ultimately alleviates psychological and physical symptoms associated with body dysphoria.

**Affirmative sexual partner and sexual satisfaction findings.** The relationships between all variables were explored in the study. Although there was a low correlation between transgender congruence and sexual satisfaction, there was a high correlation between affirmative sexual partners and sexual satisfaction ( $r = .651, p < .000$ ). Reiterating the importance of considering the intersection of identities within a relationship, a trans person's identity directly impacts their relationship with partner(s). The results indicate that as a sexual partner's level of affirmation increases, sexual satisfaction will increase for the trans masculine partner.

Therefore, it is important to discuss possible ways affirmation may increase sexual satisfaction.

The interaction of connecting intimately to a trans person requires a deeper level of gender affirmation from a sexual partner. The qualitative study by Martin and Coolhart (2019) that informed this study generated a major subtheme- relational aspects, which then developed into the Affirmative Sexual Partner Scale. Themes of affirmation included safety, connection, attraction, support, feedback, and communication. It is important to expand on these subthemes to provide direct examples of how affirmation of a sexual partner correlates highly to sexual satisfaction.

*Affirmation defined.* Affirmation included aspects of safety, connection, attraction, support, feedback, and communication. Since sexual satisfaction is an individual experience, for someone who identifies as trans masculine, affirmation can be a part of satisfaction. As McClelland (2010) notes, gender minority status creates limitations as the focus is often on cisheteronormative experiences. Previous research has highlighted the ways that body dysphoria influences sexual behavior, reducing the body's availability (Bliss & Horne, 2005). Therefore, by including these aspects of affirmation, sexual satisfaction becomes an intimate process that a partner can naturally increase. Remaining aligned with McClelland's (2010; 2014) theory of developing an interpersonal definition of sexual satisfaction; the findings of this study indicate that a partner's level of affirmation increases sexual satisfaction. Being seen as male is an important affirmation that allows the trans masculine partner to explore sexuality that previously was not available (Davidmann et al., 2014; Bockting et al., 2014). These aspects of affirmation, addressing connection, attraction, and safety used in this study parallel previous research that found relationships between emotional closeness and sexual satisfaction (Chatterji et al., 2017; Kaestle & Halpern, 2007; McClelland, 2014).

Communication was an additional item addressed within the Affirmative Sexual Partner Scale that can increase sexual satisfaction. Sexual identity, gender identity, and emotional safety depend on the level of communication within a relationship to increase sexual satisfaction. Numerous studies have explored the impact of communication on sexual satisfaction, finding that communication increases sexual satisfaction (Chatterji et al., 2014; Fahs, 2014; Holmberg & Blair, 2009; Jones et al., 2017; Štulhofer, Ferreira, & Landripet, 2014). Masters and Johnson (1970) derived their main interventions in sex therapy based on communication that was later replicated by Jones, Robinson, and Seedall (2018). Although these were studies with cisgender couples, both researchers found that greater amounts of sexual communication led to an increase in sexual satisfaction. For someone who identifies as trans masculine, this open communication can lead to expressing needs and desires during sex. Open communication within the relationship creates comfort, security, improved intimacy, and sexual satisfaction.

A trans identity which often includes dysphoria directly impacts sexuality as primary sex characteristics do not align. For trans people with dysphoria often language captures their mental experience of sex (Langer, 2014). Language used to describe anatomically male body parts can affirm gender identity for trans masculine people. Communication from partners can be affirmative by remapping the body and using these labels of body parts that affirm gender identity. It is worth noting that communication should be emphasized within this study, which was found to correlate highly with sexual satisfaction.

Another aspect of affirmation comes from the physical pleasure aspect of sexual interaction through the connection. Sexual satisfaction could be defined through giving and witnessing pleasure from their partner(s). Since trans masculine people often experience distress within their own body, creating sexual scripts that focus on the partner's pleasure may reduce

feelings of dysphoria, increasing self-esteem. Chatterji et al. (2014) found that partner gratification increased satisfaction for the giving partner. Gender euphoria could be found in the partner's physical pleasure. Going back to McClelland's (2014) model, the partner's physical pleasure was a marker of sexual satisfaction. Witnessing this pleasure can create sexual satisfaction by creating emotional closeness. The preliminary qualitative study by Martin and Coolhart (2019) reiterated this finding as participants explained witnessing their partner's pleasure increased their satisfaction. Dissociation from the physical body because of dysphoria can often occur, but the trans person may be grounded by experiencing their partner's pleasure.

***Sexual identity.*** The last intersection that trans people may find affirmation through leading to sexual satisfaction is the partner's sexual identity. The partner's sexual identity has the power to impact dysphoria directly by creating a connection that validates the trans person's sexual identity. For example, a trans masculine person who identifies as straight, may find it affirming to date a straight woman. Also, a gay trans masculine person might find it affirming to date a gay man. Sexual identities provide language to sexual activities and body parts that reduce dysphoria, increasing sexual satisfaction. Language that comes with sexual identity is often affirmative of sexual experiences (Williams et al., 2013). The ability for partners to relate to a trans man in gender and sexual identity specific ways creates a more fulfilling sex life (Langer, 2014). Dozier (2005) reiterates that gendered language and meanings created in sexual interactions become the basis of sexuality. This subtheme connects directly to communication as sexual identity provides language that allows the mental body part to be a part of sexual experiences, reducing overall dysphoria (Bettcher, 2014).

This study highlights the need for support and validation from a sexual partner. Prior research shows that partner affirmation around identity decreases overall distress and could

increase sexual satisfaction (Tree-McGrath et al., 2018). Since partners play an active role in decreasing dysphoria (Lindroth et al., 2017) and increasing sexual satisfaction (Bartolucci et al., 2015), it is vital that partners of trans masculine people remain affirmative to access their desired sexual behavior and desires. Trans masculine people can use their sexuality to create empowerment and define their own sexual satisfaction; this gender euphoria is accessible by affirmation from a sexual partner with key findings from research question one, worth noting:

- As the level of affirmation from a sexual partner increases, sexual satisfaction of the trans masculine participant increases
- Affirmation includes- safety, connection, attraction, support, feedback, and communication

### **Research Question Two**

Considering the correlation between affirmative sexual partners and sexual satisfaction, the researcher was interested in exploring if moderation was occurring. Using affirmative sexual partners as the moderator, a moderation analysis was conducted between transgender congruence and sexual satisfaction. The results of the analysis indicated, there was a significant relationship between transgender congruence and sexual satisfaction. Following this a model was run with the interaction variable, finding that affirmative sexual partners did moderate the relationship between transgender congruence and sexual satisfaction. This is a positive finding, indicating that an affirmative sexual partner can have an impact on sexual satisfaction for the trans masculine person. It appears that affirmative partners have a direct relationship with sexual satisfaction, signifying an interpersonal experience. Further exploring the model and connecting to the previous correlations, transgender congruence may be an individual experience for the participants. Transgender congruence was significantly significant, but the correlation strength



was low with both affirmative sexual partners or sexual satisfaction. This indicates an individual experience, and perhaps the level of affirmation from a sexual partner through their behaviors may not be powerful enough to influence transgender congruence but can influence sexual satisfaction.

**Rationale.** It is important to connect this theory to previous research and draw in reasoning that supports the statistical findings. The literature that predominantly connects is Pfeffer's (2008; 2017) research on trans men and their cisgender women partners. Pfeffer (2008) explains in her study that low transgender congruence was always the omnipresent factor throughout all her content analyses of research and published literature by trans men. Although, she notes that this is not surprising given the trans identity and accompaniment of dysphoria, she was in awe of the language intensity. Pfeffer (2008) noted that the way that trans men articulated their body revealed saddening language such as disgust, hatred, torture, horror, and dissociation. The author refers to a passage by Sennett (2006), "Being in the wrong body is a crime. Death is appealing to those of us, who are encased in the wrong shell, who are trapped in a flesh of darkness, that ... sickens us to the point of madness" (p.33). Pfeffer (2008) goes on to highlight how body image is a process filled with intense struggle that often partners cannot aid in easing dysphoria.

This interpersonal process often has a considerable influence on sharing the body sexually with others. Pfeffer (2008) explained the mutual feeling of emotional and sexual isolation, as the participants noted communication and language often was blocked. In other words, the intense body dysphoria created an emotional and physical wall between partners. With this being said, the findings of the current study lend support to the idea that transgender congruence has a low correlation to the variables, and transgender congruence could solely be an

individual experience. However, a partner does have an impact on sexual satisfaction through both the mental and physical experience of sexual satisfaction.

**Affirmation.** The Affirmative Sexual Partner Scale addressed eight items that provide direct examples of affirmation that was shown to moderate the relationship between the dysphoria that occurred impacting sexual satisfaction. Affirmation from a sexual partner can create security for the trans masculine person. Safety is an overarching characteristic needed in healthy relationships as professed by multiple attachment theorists (Murray & Holmes, 1997). Safety can include both physical and emotion safety, specifically compounded for someone with a trans masculine identity that constantly faces discrimination from multiple systems. Through safety as the foundation, trans masculine people can develop healthy connections with their partners as they explore sexuality.

The complexity of gender identity and transition often impacts self-esteem. As the minority stress model highlights, the transgender community constantly faces discrimination and victimization influencing wellbeing and self-esteem (Austin, 2016). However, a partner can provide a buffer to this experience through attraction, support, and feedback around their gender identity. Pfeffer (2017) notes that often the mind becomes so powerful in sexual relationships that a partner can increase sexual satisfaction just by seeing their partner as male. In all sexual relationships, sexual interactions have the power to validate identities (Dozier, 2005). However, when someone incorporates a trans gender identity to this equation, the interaction is often intensified. This trans embodiment that can occur between partners has the power to increase self-esteem. This is reiterated in a study by Williams, Weinberg and Rosenberger (2013) who found that comfort with a trans masculine person's body was often impacted by their partners' acceptance and comfort of their body as male. The affirmation is shown through the expressed

attraction, support of their gender, and feedback they receive from their partner.

The last item, communication was an important aspect of affirmation that can lead to sexual satisfaction. Langer (2014) highlights the role that language plays in the mental experience of sex. A sexual partner can use communication to explicitly describe the trans person's body, increasing their overall sexual satisfaction in that moment. Although academic research is limited, autobiographies have highlighted the ways that partners co-construct their sexuality. Pfeffer (2017) notes the connection between the physical and mental space for trans men and the connection that grows through communication around their gendered self during sex. As partners adapt language to their body partners, they develop a sense of physical and emotional connection in the way that their bodies relate to one another.

Moderation revealed that this interaction directly influences the level of sexual satisfaction experienced despite low transgender congruence. By remaining cognizant of the trans person's experience of transgender congruence, clinicians can work to address dysphoria. Then by remaining systemic, clinicians can address aspects of affirmation for the sexual partner to help increase sexual satisfaction and increase transgender congruence. For many, as Pfeffer (2017) notes, trans masculine people and their partners can gain broader access to sexual behaviors, connection, and a satisfying sexual relationship through communication. Key findings from research question two of ways that a sexual partner can provide affirmation:

- Provide a safe and secure connection
- Express physical attraction
- Support gender identity
- Validate and provide positive feedback about masculine identity
- Communicate and regularly check in on sexual needs

## **Limitations**

There are several limitations generated in this research study. It is important to note that the decision to focus on sexuality was the researcher's choice driven from lack of literature, not intended to over sexualize trans people, rather give voice to the extensive impact body dysphoria has on all aspects of the trans experience. Limitations arose from measures, data collection, demographics, and follow up question. Since this was a quantitative study, a first step would be conducting qualitative studies to address these issues head on, since limitations fall within the measures. It would be beneficial to use interviews to form more congruent measures based on accurate language and experiences for this community.

**Measures.** The first limitation was the language of the measures used in the survey. The two existing measures that addressed transgender congruence and sexual satisfaction contained questions that were non-inclusive to poly identified participants. Although the survey attempted to be non-monogamous orientated, these measures were not as inclusive to poly identified participants. Additionally, the New Sexual Satisfaction Scale did not include questions that specifically intertwined transgender congruence and sexuality. The New Sexual Satisfaction Scale was developed with cisgender populations. A new sexual satisfaction scale is needed to directly address sexuality for the trans masculine population even though the measure developers (Štulhofer et al., 2010) used neutral language and intended their measure to be used with any gender/sexual identity.

This study can inform the development of scales that benefit the transgender population and more directly address sexual issues. Although the Affirmative Sexual Partner Scale and Transgender Congruence Scale addressed trans participants directly, the New Sexual Satisfaction Scale did not address the complexities of their gender identity and sexuality. By developing a

more sexually affirmative scale, aspects of identity that influence sexuality are directly addressed such as how to navigate and increase transgender congruence during sexual situations. In the same way, Kuyper and Wijsen (2014) while exploring gender identity and dysphoria, found that existing measures often do not validate exact experiences, leaving the researchers to adapt with different scales.

The data analyses revealed further limitations with the measures. Specifically, for the Affirmative Sexual Partner Scale, the fit indices revealed that the first confirmatory factor analysis was a good fit, with the original 15 items. However, when the items were removed that did not address the research question at hand for the trans masculine person and their partner, the 8-item scale was not a great fit and all the fit indices were outside of the parameters. Although, this did not fit well for the current study, this is useful, indicating that the scale provides future directions to be manipulated in the future to better fit the population. Perhaps, because the age of the sample was predominately young, their overall experiences of dysphoria, sexual satisfaction, and affirmative sexual partners were low. Future studies could ask more direct questions that focus on different age groups of trans masculine people to further explore how their age and stage in transition impacts their experiences.

**Data collection.** Another limitation was the method of data collection through social media platforms and affirmative medical and mental health providers. By using these resources, those who occupy these spaces often receive support around processing their identities, as shown by the high percentage of therapy seeking individuals. In this sense, the research study provides bias in reaching those who have access to resources such as the Internet, fueling more exploration into gender and sexuality. This process neglects to address the whole picture, including others in the community who may not have access to these resources. In addition, the

use of social media groups often involves occupying specific identities to join the groups. Multiple identities that I occupy such as age and gender identity history limited my accessibility to many private groups. A potential drawback of using this data collection strategy is the possibility that the same participant could have responded more than once. Using Qualtrics, I attempted to prevent participants from taking a survey more than once by enabling the “Prevent Ballot Box Stuffing” option. This limited participants from taking the survey multiple times by placing a cookie on the browser that prevents them from taking the survey again. However, there are still risks, such as a participant clearing the cookie, using a different browser, or device.

Additionally, I did not address my gender history in the recruitment flyer, which arguably could have created an aversion for potential participants. Participants may have felt safer if they were aware of my gender history. In addition, the lack of funding for this survey may have pushed participants away. Potential participants may have had unsettled feelings about gaining research from a marginalized community without proper compensation, which was noted in the feedback question of the data. Finally, it is important to situate myself as the researcher, explore my own gender history, and self-reflection from this study.

**Demographics.** Although participants were collected from an international sample, the data was gathered from a western lens, limiting language and conceptualizations of sexuality. Future research could address levels of comfort around sexuality based on geographic location exploring how culture and identity intersect. My experience and identity as a white, male researcher limited my conceptualization of the variables, transgender congruence, affirmative sexual partners, and sexual satisfaction. A limitation was not comparing US participants to international participants. There are vast differences in Western cultures views of sexuality including kissing, foreplay, oral sex, and LGBT sexuality. Sexuality exists on a spectrum that

some societies encourage and some consider taboo. To remain intersectional moving forward, a study on differences in culture experiences of sexuality could provide more insight.

The choice was made to focus specifically on sexual relationships versus committed romantic relationships. This decision allowed more responses from participants that may be polyamorous or engage in hook-ups. The strength of this decision includes a focus more on sexual encounters specifically and not the dynamics of relationships. However, this could also be seen as a limitation as those who are in more long term committed relationships may have had more conversations around sexuality and increasing affirmation during sexual activity. Future research could address specific relationship timeframes and compare those in long term versus short term sexual relationships.

Time into transition may impact a trans person's experience of their sexuality. However, the questions did not specifically ask for time into transition rather a baseline of hormones or surgery. Typically, it has been found that those early in transition often restrict their sexual activities due to body dysphoria and pressure to adhere to rigid gender roles (Brown, 2010). Perhaps those who have had bottom surgery have an entirely different experience around sexual satisfaction. Additionally, data collected by age and time into transition was not collected. Generational differences and accessibility to resources directly impacts transition. Identities impact who participates in the survey, those who identify as stealth are less likely to participate, although there was the option to identify as male, the call for research indicated identity of trans masculine.

**Follow up question.** The question “Do you feel that this survey accurately captured your experiences? If not, is there anything you would like to add? Please feel free to provide feedback” concluded the survey. By including this, the question allowed participants space to

express their thoughts and critique the survey in itself. In total 403 out of 1,041 participants (38.7%) responded to the feedback question. Feedback included that these participants felt that the survey was not polyamorous friendly, others wished they had received monetary compensation, and a large handful disclosed personal reflections on their experiences of sexuality and body dysphoria. My goal for this question was to provide a space for therapeutic reflection on the survey, paralleling my stance as a clinician. This space is extremely important for a vulnerable population that is often evaluated and taken advantage of by researchers. The data from this final question revealed more critiques of my survey versus reflection. Knowing this outcome, the final question could have been reworded, not using the word “feedback” which allowed more critiques versus my intended goal. Instead the following may have provided more insight, “ If needed, please use this space to provide personal reflection on sexuality and body dysphoria” to better achieve my goal of being respectful and affirmative.

### **Self of the Researcher**

My identities inherently influence how I interact with participants and conduct research. I identify as an able-bodied, white, Christian, straight man. My family background consists of Dutch and German descent, raised Lutheran, middle socioeconomic status, and resided in northern, midwestern, and southern states. My personal background consists of an athletic past at the collegiate level and prior service in the United States Air Force. Professionally, I am a couple and family therapist and currently a doctoral candidate.

Although all of my identities inform my work as a therapist and researcher, I place a focus on my sex and gender identity as the biggest influences for this study. As far back as I can remember I have always identified as male. However, I was robbed of this identity at birth when a doctor placed an “F” on my birth certificate, shaping my formative years. Throughout



childhood, I never questioned my gender until someone told me that I was not a boy, which led to years of suicidal thoughts, confusion, depression, and rebellion. The busyness of my athletic life and my family system's beliefs did not leave space for gender to be an area of conversation. My gender identity was not explored in childhood, yet molded into society's standards and expectations based on that "F."

As I neared young adulthood, with years of turmoil and distress of presenting my false self, I found hope. My years of intentional distraction halted in my mid-twenties when I stumbled upon a photo of a man with scars on his chest. This led to a euphoric deeper exploration of physical transition and the options available for reaching physical congruence. During this time, I realized what my purpose in life was: to be a therapist and an ally to those with similar stories. As someone who does not identify as transgender, since I have not transitioned genders and have always identified as male, the disclosure of my sex assigned at birth is only necessary in research and clinical arenas when I know that it will improve the relationship with clients or participants. For this reason, I did not disclose my gender history during the recruitment process.

Personally, I hold a very strong social justice lens and find passion in helping others. In relation to the LGBTQ community, I have many personal connections with friends who have experienced discrimination because of their gender and/or sexual identity. As I spent the majority of my teenage years in the Deep South, there was not access to language, representation of diverse identities, or experiences in regards to LGBTQ issues. Many of my teammates, friends, and I experienced physical and verbal harassment for our gender and/or sexual identities. These damaging experiences left an imprint on my experience of self and an inability to voice issues that I felt strongly about. I internalized these experiences for years, as spaces that I was a

part of did not allow processing, which was necessary to heal. In time, I was able to find passion through my clinical work, wanting to be a voice of acceptance and validation for others that I never had the opportunity to receive. I have the desire to create space for self-expression, giving voice to transgender people that respects and accepts all realities, and validates their experiences. As an ally, I find joy in conversing with people who have pride in their identities and are a part of strong support systems.

As I explored myself and the implications that my identities bring into my work, I discovered that not only was I struggling with my gender identity, but I was struggling internally to express my straight sexual identity with the wrong external presentation. Prior to medical transition, as someone with an attraction to cisgender women, I rejected society's labels, yet constantly defended myself in social situations as straight. Throughout my teenage years as peers were developing sexually and having sexual experiences, I was often isolated with no one to process my internal thoughts. Sexual education classes, the media, and peers did not discuss sexuality outside of two heterosexual cisgender partners. These representations of sexuality created a burden and sadness, with years of wishing I were biologically male. Mental health providers, doctors, family, and friends silenced and shamed these thoughts causing internalized negativity around my sexual development. I often found myself wishing that I had someone to talk to and not feel rejected.

My sexual identity development offered extreme complexity through body dysphoria, unlike many of my cisgender peers. With years of self-hatred and disgust, I was often closed off and intimacy remained a large part of my life that I always longed to fulfill. My body incongruence presented a barrier and an inability to understand the true implications of my dysphoria. Additionally, I experienced negativity from society that not only made language

inaccessible, but anything outside of religious and media implications at the time, abnormal. However, as times have evolved, those in the community have created ways to navigate this dysphoria. Through time with congruency and positive relational experiences, I was able to find resiliency, peace, and self-love.

As the research suggests, medical transition can lessen the experience of body dysphoria in sexual situations leading to sexual satisfaction (van de Grift et al., 2017). However, the research that examines the connection between all three variables of transgender congruence, sexual satisfaction, and sexual partners is limited. Cisgender scholars have produced the majority of literature on transgender sexual health experiences (Levy, 2013). This is beneficial as allies and it is also critical to promote voices who have lived experiences in scholarly production. My personal experiences drive my passion for this study, to create research that shared aspects of struggles and resiliency of marginalized populations. My goal was to create research that normalized and created community for the trans masculine population. If I can help guarantee that one less person will experience the confusion and silence that I felt, that is healing.

### **Clinical Implications**

The findings from this study are helpful for mental health clinicians, the trans masculine community, and their sexual partners. Clinicians should be comfortable and educated in working with and discussing aspects that encompass a trans identity and specifically, trans sexuality. In this study, participants had varying differences of sexual and gender identities. As discussed earlier, often the media highlights linear journeys through medical transition or only representation of straight trans masculine binary people. This presentation may lead a transgender person who does not identify as binary to feel anxiety in relation to their identity

and/or transition experience. It is important for clinicians to maintain a safe and open environment for trans masculine clients to discuss their diverse experiences of sexuality and gender identity. Although a majority of the sample identified as binary, non-binary identities were also represented, which may include different desired avenues for transition. It is recommended that clinicians take the time to understand their clients' identities, and build rapport based on their experience versus the traditional trans narrative.

It is crucial to provide a supportive space for trans clients to discuss their experiences that often are internalized for many years. It is recommended that clinicians learn from their clients about their sexuality from their lived experiences. Often dysphoria directly impacts the sexual self, creating distress for trans people. For trans masculine people, sexuality often includes biological, social, and psychological aspects that are discriminated against by society's gender binary (Thurston & Allan, 2018). It would be beneficial to unpack these standards with clients and explore how it impacts their being in the world. Clinicians should rethink sexuality, staying away from cultural assumptions around bodies and masculinity (Schilt & Windsor, 2014). In order to grasp the total experience of someone who has a trans identity, it is important to understand the mental experience that low transgender congruence entails. Managing dysphoria also includes confirmation and management around sexual issues which evolve throughout transition (Holmberg, Arver, & Dhejne, 2019) Often dysphoria is actively present, it may come up in certain scenarios, or trans people may have been battling it for so long they neglect to realize its implications. Clinicians can create a better joining process by understanding the anxiety, depression, and isolation that low transgender congruence brings.

**Preventing gatekeeping.** Society often highlights medical transitions, and clients may not be ready for those steps or be emotionally, financially, or physically prepared. Although

clinicians have a duty to write medical necessity letters for medical transition when needed, trans clients may need additional support around various topics. It is necessary to distinguish whether a client just needs a letter for medical transition and to prevent therapists role as gate keeper. It is important for clinicians to be educated on ways to increase transgender congruence and various coping mechanisms for the mental health issues that dysphoria brings. Additionally, it is a therapists' duty to hold a space where medical transition can be discussed freely. When/if clients are ready to begin hormones, top surgery, or bottom surgery, it is imperative that clinicians are prepared to answer questions and direct clients to the appropriate facility for care. For clients who are over 18, like those in this study, clinicians can direct them to informed consent clinics to begin testosterone. However, many general practitioners and family doctors are open to prescribing hormones, if a client feels more comfortable being under their doctor's direct care.

**Continuing education and support.** Currently, a high number of plastic surgeons in the United States are performing top surgery, with insurance covering this procedure. Clinicians should be familiar with the closest surgeons and coordinate care for their client. Bottom surgery, also covered by insurance for now, has only a small number of surgeons in the nation conducting this procedure. This surgery is more invasive and often takes years of training with all surgeons using different techniques. It is extremely important that clinicians research procedures and grasp which surgeons are affirmative, accurately trained, and conducting surgery with the best outcome. The complexity behind bottom surgery requires years of research and steps for preparation that clinicians should be informed of to better direct and support their clients. Clinicians should be aware of clinics that offer affirmative STI, PREP, and gynecological affirmative care for trans masculine people. Often, trans people are tasked with informing their

therapists, which can create a huge burden and feeling of exhaustion. Additionally, it is important to understand that not all trans people experience the same amount of dysphoria and may feel gender euphoria with or without medical intervention. Clinicians should be prepared to support clients through any decision.

Lastly, since most graduate programs do not include clinical training around trans issues, it is important that clinicians commit to being affirmative with trans clients; seek out additional training and education (Shipman & Martin, 2019). Additionally, it is important to remain supportive around sexuality in general, using the same knowledge that supports cisgender sexuality and not become “too transgender specific” (Holmberg et al., 2019, p. 133). By exploring the sexuality of trans masculine people, stigma can be reduced, contributing to more positive sexual experiences (Nikkelen & Kreukels, 2018). Overall, it is recommended that clinicians:

- Understand the dynamics of transgender congruence that intersect with identities
- Retain a not knowing stance and listen to client’s experiences of their sexuality
- Help develop coping mechanisms for managing body dysphoria during sex
- Continuous education on trans identity and sexuality
- Ongoing research on medical transition, resources, and support groups for clients

**Therapist recommendations.** Sexuality often remains a taboo topic in Western society. However, it is important for clinicians to be comfortable discussing sexuality with all clients. For clients who identify as trans masculine, it is recommended that clinicians understand the fluidity of sexuality and step away from gender stereotypes. It is important that clinicians open the window for clients and their partners to describe their sexual issues when necessary in session. By remaining affirmative, clients may feel comfort opening up about their struggles. It

is necessary that clinicians do not assume sexual identity based on presentation, instead use gender-neutral language until the client voices pronouns for their partner(s) and themselves.

The current study highlighted many topics couples may need to process together. Sexual relationships noted are integral to well-being, but research often neglects expanding on these dynamics of sexual practices (Pfeffer, 2017). The ways partners co-construct their sexuality may be an area that is discussed freely or needs to be pushed for deeper discussion from a therapist. It is constructive for the therapist to incorporate conversation around sexuality with clients and model that same communication with their partners.

**Therapist encouraging communication.** The idea of connection and safety lays the foundation for comfort sexually. For example, if a trans masculine person feels safe with their partner they may be more willing to have beginning conversations around their sexual needs. These conversations can lead to discussion around unpacking their gender identity and dysphoria. Communication involves sharing their perception of their gender identity in ways that their partner, especially if they are cisgender, may not experience on a daily basis. Therapists can assist in providing conversation starters for unpacking gender history, which may be important to increase connection between partners.

This ongoing communication can evolve into deeper sexual needs, including boundaries and sexual satisfaction. Trans masculine people may experience resistance to sharing their body sexuality. However, if partners can establish boundaries prior to engaging in sex, a trans masculine person may experience higher sexual satisfaction. Many participants in Martin and Coolhart's (2019) study expressed boundaries they have with their sexual partners. A few examples included shutting the lights off during sex, keeping a binder on, or having certain parts of the trans masculine person's body off limits. This negotiation of boundaries helped partners

understand ways that sexual touch or acts create comfort or discomfort. If partners of trans masculine people can hold a space that allows transparent conversation, they could experience greater ease when it comes to the vulnerability of sharing their body sexually.

Clients may be interested in learning ways to improve their sex life that is often masked by dysphoria. Clinicians can assist trans masculine people and their partners in developing coping mechanisms to navigate body dysphoria during sexual activity. Following the theme of communication, shifting language to terms that are associated with male body parts may be more appropriate. Clinicians could lead a conversation that includes discussion around terms that fit for the trans masculine person and how to utilize them during sex. Conversation could also include a deeper discussion of prosthetics or sex toys that could enhance sexual satisfaction. The assistance of these practices could help partners develop a stronger sense of connection with their imagined genitals. Pfeffer (2017) explored narratives of cisgender women partners of trans men specifically around bodies, sexuality, and intimacy. She noted the imagination and ‘fantasy penis’ that many participants use during moments of intimacy, ultimately creating deeper sexual satisfaction for both partners. A clinician having knowledge of prosthetics, sex toys, or ideas to address sexual issues and dysphoria may make clients feel more normalized and accepted.

**Integrative approach.** Early sex therapists, Masters and Johnson, often focused on the functionality of sexuality and orgasm, or lack thereof. During this era of medical and genital focus, interventions did not provide a cure all and since then many couples therapists have provided alternative models. A more integrated approach included addressing aspects of conversation, attachment, and connection (Leiblum, 2007). Johnson and Zuccarini (2011) discuss the importance of security and emotional accessibility that shape physical and sexual pleasure. These ideas help propel the argument that communication is a key part of affirmation



for a trans masculine identified couple. In the moment, trans masculine people may have needs in order to perform sexually. However, without conversation prior, the trans masculine person could have intense moments of dysphoria.

Trans masculine sexuality may transcend the ideas of sex and the various interactions of bodies. Often partners are experiencing the same subjective experience through narration of the sexual experience. Pfeffer (2017) highlights that the power of words creates a reality of the way that bodies exist in relationship. Affirmation can be a continuous ‘foreplay’ of conversation that leads to more positive sexual interactions. Through safety, connection, communication around attraction and sexual needs, and support with positive feedback of gender identity, trans masculine people and their partners can have greater access to sexuality and sexual satisfaction. It is recommended that clinicians remain relational; some important points to address with trans masculine including couples:

- Hold conversations around the relational intersection of identities and dysphoria
- Describe how they co-constructed their sexual connection
- Expand on communication around sexuality
- Explore sexual boundaries, desires, and needs
- Process sexual satisfaction, both individually and relationally
- Inquire about ways to navigate dysphoria through language and practice

### **Future Research**

The results of this study provided answers to the two research questions. However, the data has created opportunities for future research. Three variables were explored in this study, which resulted in separation of one of the variables. Transgender congruence was explored further linking with demographic data. However, moving forward it is important to understand

why transgender congruence had a low correlation with variables such as age, gender identity, and sexual identity. Perhaps future research could explore the mental health issues that are persistent with dysphoria, such as anxiety or depression. Research that generates further understanding could aid therapists to become advocates and reduce these negative mental health outcomes. The findings indicated a high correlation between affirmative sexual partners and sexual satisfaction that could be expanded on in future research. Future studies could unpack sexual satisfaction for trans masculine people and better understand how they define sexual satisfaction.

**Demographics.** The strong post hoc analyses provide implications for future research. Significant variables found in this study such as non-binary identities, demisexual sexual identities, and age could be controlled for in future studies. For example, those who identify as non-binary have a distinct transition experience that has received little attention in research (Pulice-Farrow, Brown, & Galupo et al., 2017). A majority of transgender research focuses on binary identities, often with linear transition (Moradi et al., 2016). Although accepted in many cultures, Western society limits the understanding of non-binary identities and struggles to accept basic gender-neutral pronoun usage. It is important that clinicians recognize and validate non-binary identities (Matsuno & Budge, 2017). Research has indicated that non-binary people experience greater risk for negative mental health outcomes than binary trans people (James et al., 2015). The report of the 2015 US Transgender Survey indicated that psychological distress was exceedingly higher for non-binary respondents. Additionally, higher levels of anxiety and depression, as clinicians often have little knowledge and awareness of these identities (Hendricks & Testa, 2012). Future research could focus on how development differs for non-binary trans people, addressing medical transition options and diverse narratives. Providing more research on

non-binary identities also increases responsibility for surgeons to validate their experience. Historically, the medical community was trained in understanding transgender identities in terms of MTF and FTM and a linear transition from one gender to the next. By exploring their direct experiences, those who work with the non-binary population could provide better affirmative care. These variables could also inform future instruments to be more inclusive of various identities that currently do not receive as much attention in the literature.

**Trans feminine.** Another area of identity to be examined further within trans research is the trans feminine community. Those who are assigned male at birth and identify as women or feminine have a different experience navigating transgender congruence, sexual partners, and sexual satisfaction. Unfortunately, a majority of previous research has focused on the negative aspects of these identities, including violence and discrimination. Trans feminine persons often encounter discrimination from multiple systems, living in the aftermath of trauma. The U.S. Transgender Survey highlighted the large proportion of violence, assault, and negative mental health issues trans feminine persons face (James et al., 2016). Research that explores more direct associations between trans feminine persons and their partners is lacking, with some studies addressing the effect of minority stress on the relationship (Gamarel et al., 2014). Future research could include more diverse trans feminine identities and explore the same or different variables.

**Intersectionality.** Future research should examine the multiple intersectional identities that trans masculine participants occupy. The study did not examine the effect of navigating identities such as disability, race, or age. These identities may directly impact levels of dysphoria, sexual partners, and sexual satisfaction. A majority of this sample identified as white, which limits understanding of racial diversity. Future research might explore the impact of

having diverse racial identities and intersection with gender more directly. Studies should pay attention to single groups of identities, instead of trans masculine people in general, more specifically an older trans masculine sample or trans masculine people of color.

Additional research is needed to gather a more in depth experience of sexual satisfaction for trans masculine people. Previous studies have addressed the impact that dysphoria has on sexual performance; often leading to aversion and shame that in turn affects partnered sex (Bunger, Steensma, Cohen-Kettenis, & De Vries, 2017). However, more positive aspects of sexual performance and defining sexual satisfaction have not been addressed. The research conducted in this study could lead to development of a new measure that addresses sexual satisfaction directly. The results of this research do not indicate a strong connection between body dysphoria and sexual satisfaction; however, there are important factors aside from affirmative sexual partners that influence sexual satisfaction. Future research might explore the relationship that trans masculine people have with their body sexually, without taking into consideration the partner's influence.

Overall, qualitative research could benefit this population giving more direct insight into their thoughts, feelings, and experiences. Stepping away from quantitative methods can allow for more freedom for participants to connect to the research at a broader level. This methodology focuses more on the individuals or couples and their stories. Differences in demographic information can be identified more directly from qualitative research. Conducting interviews with this population allows space for marginal voices to be heard and validated. The current study created a basic understanding of the experiences of trans masculine people in regard to transgender congruence, sexual partners, and sexual satisfaction that future research can build upon.

## Conclusion

This quantitative research study was conducted because there is little research on sexual practices and trans masculine couple negotiation and how it affects their sexual relationships (Lev & Sennott, 2012). This study examined the trans masculine experiences of transgender congruence, affirmative sexual partners, and sexual satisfaction through the Transgender Congruence Scale, Affirmative Sexual Partner Scale, and the New Sexual Satisfaction Scale. It is important to explore trans masculine identities as clinical literatures notes that body dysphoria creates sexual isolation that impacts partnering and sexuality (Lev, 2018). Affirmative sexual partners were found to moderate the relationship between transgender congruence and sexual satisfaction. The data analyzed and collected from the study can be used to help inform clinicians, the trans masculine community, and their sexual partners.

Transgender people often experience a lag in sexual development as growing up transgender limits sexual self-discovery (Doorduyn & van Berlo, 2014). This journey greatly influences sexuality development and experiences due to the lack of body congruence. However, gender embodiment through identity exploration, awareness, and social/medical transition can lead to a desire for sexuality, which is not taken for granted. Often sexuality is stunted until age of gender identity realization, transition, and/or coming out (Rowniak & Chesla, 2013). Sexuality can be expressed from the body's interior through behavior and interaction. By rediscovering the sexual self after the transformation of bodies, trans people may experience resiliency and euphoria during sexual activities by learning sexual preferences and partner desires.

It is important to focus on positive aspects of relationships and give attention to support and affirmation from those partnered with trans masculine people. Partners can have such a

positive impact on trans masculine people's perceptions of themselves sexually (Devor, 2005). Sexual partners can play a key role in providing affirmation through safety, connection, attraction, support, validating their partner's gender identity, and communication. Often erotic interaction involves mental processes with partner that create meaning, playing out the trans masculine person's internal truth, leading to sexual satisfaction. Ultimately transgender congruence and affirmative sexual partners can intertwine together influencing sexual satisfaction.

## Appendix A

### Recruitment Flyer

IRB #: 18-405

#### **Identify as Trans Masculine?**

#### **Would you like to offer insight about your experiences by participating in research?**

My name is Tristan Martin and I am a doctoral candidate at Syracuse University. The purpose of this trans-affirmative study is to better understand the impact of body dysphoria on sexual satisfaction with regard to affirmative sexual partner relationships. I hope that this information will benefit the trans masculine community and educate mental health professionals to provide better support.

- To take this online survey, you must be,

- 18+
- Assigned female at birth, current trans masculine identity (e.g. FtM, trans man, trans, transgender, non-binary, trans masculine, male, man, genderqueer, etc.)
- Sexually active with a partner in the past or present

If you have any questions, or are interested in finding out more about this research and your potential participation, please contact me:

Tristan Martin (315) 925-7034 or tkmartin@syr.edu

## Appendix B

### Consent Form



Syracuse University IRB Approved

JAN 22 2019

JAN 21 2020

#### SYRACUSE UNIVERSITY

DEPARTMENT OF MARRIAGE AND FAMILY THERAPY  
DAVID B. FALK COLLEGE  
OF SPORT AND HUMAN DYNAMICS

IRB #: 18-405

#### **Project Title- Body Dysphoria and Sexual Satisfaction in Trans Masculine Adults: The Role of Affirmative Sexual Partner Relationships**

My name is Tristan Martin, and I am a doctoral candidate in the Marriage and Family Therapy program at Syracuse University. My advisor, Dr. Deb Coolhart will be available for my mentorship during this research study. I am inviting you to participate in a research study. Involvement in the study is voluntary, so you may choose to participate and/or withdraw at any time if desired.

#### **Background/Purpose:**

You are being asked to participate in this study because you have experience living as a trans masculine person. The purpose of the study is to understand the impact of body dysphoria on sexual satisfaction while considering the role of sexual partners. Whether you currently have a sexual partner(s), or have had sexual partner(s) in the past, this survey will help us to further understand the role of body dysphoria, sexual satisfaction, and affirmative sexual partner relationships. This is a research study and not a medical or psychological treatment study. You will only be asked to describe your experiences; you will *not* be provided any medical or psychological treatment.

To take this study, you must be,

- 18 years of age or older
- Assigned female at birth but currently have a trans masculine gender identity (e.g. FtM, trans man, trans, transgender, non-binary, trans masculine, male, man, genderqueer, etc.)
- Sexually active with a partner in the past or present

#### **Procedures:**

If you agree to participate, you will be asked to complete an online survey about your experiences of body dysphoria, sexual satisfaction, and sexual partners, which should only take about 15-20 minutes. Your involvement in the study is voluntary, and you may choose to stop at any time without penalty. Portions of this data will be used for presentations, publications, and a doctoral dissertation. Following data analysis and write up, the data will then be erased.

#### **Confidentiality:**

All information disclosed in the survey will be confidential. No identifiable information (e.g. name) will be disclosed. After data collection, Tristan Martin will analyze and de-identify all

*Departments of Child and Family Studies/ Marriage and Family Therapy/  
Public Health, Food Studies and Nutrition / Sport Management / School of Social Work  
Peck Hall 601 East Genesee Street / Syracuse, NY 13202  
315-443-9329 / Fax: 315-443-4062 / <http://falk.syr.edu>*

Consent Form 1



data and will code the data by assigning a number to each participant's responses. Tristan Martin's faculty advisor (Deb Coolhart) and his dissertation committee will have access to the de-identified data. The data will be kept securely on a locked personal laptop that only the researchers and dissertation committee will have access. *Whenever one works with e-mail or the internet there is always the risk of compromising privacy, confidentiality and/or anonymity. Your confidentiality will be maintained to the degree permitted by the technology being used. It is important for you to understand that no guarantees can be made regarding the interception of data sent via the internet by third parties.* The researchers will not release data to anyone other than individuals on the research team, unless required by law. The results of the study may be published but identifying information will not be used.

**Risks & Benefits:**

It is possible that you may experience discomfort in relating your experiences regarding body dysphoria and sexual satisfaction. This risk is minimized by your responses being voluntary and the option to withdrawal at any time. If you experience discomfort while completing the survey or in response to participation in this project, a Psychology Today link will be provide for you to locate a therapist in close proximity to where you reside or you may contact the Trans Lifeline (877-565-8860). Although you may not receive any direct benefit from this study, participants may experience feelings of validation and community. More specifically, I plan to use the findings from this project to inform the development of a doctoral dissertation to educate and provide understanding for the trans masculine community and mental health professionals.

**Contact Information:**

Please print a copy of this consent form for your records. If you have any questions about this project, feel free to contact me at (315) 925-7034 or send an email to [tkmartin@syr.edu](mailto:tkmartin@syr.edu). Additionally, please feel free to contact my faculty mentor at (315) 445-2154 or [dcoole@syr.edu](mailto:dcoole@syr.edu). Questions about your rights as a research participant should be directed to the Syracuse University Institutional Review Board at (315) 443-3013.

Kind Regards,  
Tristan Martin

PhD Candidate, LPMFT  
Syracuse University  
Marriage & Family Therapy  
[tkmartin@syr.edu](mailto:tkmartin@syr.edu)

Please indicate your consent for this study by responding to the questions below: Syracuse University IRB Approved

Yes, I consent to take part in the study JAN 22 2019 JAN 2 12020

Department of Marriage and Family Therapy  
Peck Hall 601 East Genesee Street / Syracuse, NY 13202  
315-443-9329 / Fax: 315-443-4062 / <http://falk.syr.edu> / [falk@syr.edu](mailto:falk@syr.edu)  
Consent Form 1

## Appendix C

### Measures

#### Inclusion Questions

1. Are you 18 years of age or older?  
 Yes  
 No
  
2. Were you assigned female at birth?  
 Yes  
 No
  
3. Understanding that gender identity can be complex and/or constantly evolving, which category best describes your current gender identity?  
 Trans masculine binary (e.g., FTM, trans man/male, etc.)  
 Trans masculine non-binary (e.g., agender, demi guy, genderqueer, etc.)  
 Other (please specify) \_\_\_\_\_
  
4. Have you ever been or are you currently sexually active?  
 Yes  
 No

## Demographic Questionnaire

5. What is your age?

- 18-24 years old
- 25-34 years old
- 35-44 years old
- 45-54 years old
- 55-64 years old
- 65-74 years old
- 75 years or older

6. Please select the category or categories that best represent your ethno-racial background:

- Asian/Pacific Islander
- Black or African American
- Hispanic or Latino
- Native American or American Indian
- White
- Other (please specify) \_\_\_\_\_

7. Understanding that sexual identity can be complex and/or constantly evolving, which ONE category best describes your current sexual identity?

- Asexual
- Bisexual
- Demisexual
- Gay
- Open/fluid
- Pansexual
- Queer
- Straight/heterosexual
- Other (please specify) \_\_\_\_\_

8. Where do you live?

- Midwest—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, North Dakota, South Dakota, Wisconsin
- Northeast—Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
- South—Arkansas, Alabama, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia
- West—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming
- Puerto Rico or other U.S. territories
- Other (please specify) \_\_\_\_\_

9. What is your current PERSONAL annual income from all sources?

- Less than \$10,000
- \$10,000 to less than \$20,000
- \$20,000 to less than \$30,000
- \$30,000 to less than \$40,000
- \$40,000 to less than \$50,000
- \$50,000 to less than \$60,000
- \$60,000 to less than \$80,000
- \$80,000 to less than \$100,000
- \$100,000 to less than \$150,000
- \$150,000 to less than \$200,000
- \$200,000 or more

10. If you desire hormone therapy (i.e., testosterone) have you pursued this medical intervention?

- Yes
- No
- Do not desire

11. If you desire top surgery (i.e., chest reconstruction) have you pursued this medical intervention?

- Yes
- No
- Do not desire

12. If you desire bottom surgery (i.e., phalloplasty or metoidioplasty) have you pursued this medical intervention?

- Yes
- No
- Do not desire

13. Have you ever been to therapy for assistance in gender transition (e.g., letter to support medical interventions)?

- Yes
- No

14. Have you attended therapy for other life stressors?

- Yes
- No

## Transgender Congruence Scale

Gender identity is defined as the gender(s) that you experience yourself as; it is not necessarily related to your assigned gender at birth. For the following items, please indicate the response that best describes your experience:

### Appearance Congruence:

1. My outward appearance represents my gender identity.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

2. I experience a sense of unity between my gender identity and my body.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

3. My physical appearance adequately expresses my gender identity.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

4. I am generally comfortable with how others perceive my gender identity when they look at me.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

5. My physical body represents my gender identity.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

6. The way my body currently looks does not represent my gender identity.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

7. I am happy with the way my appearance expresses my gender identity.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

8. I do not feel that my appearance reflects my gender identity.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

9. I feel that my mind and body are consistent with one another.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

### Gender Identity:

10. I am not proud of my gender identity.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

11. I am happy that I have the gender identity that I do.

1                      2                      3                      4                      5  
Strongly Disagree    Somewhat Disagree    Neither Agree nor Disagree    Somewhat Agree    Strongly Agree

12. I have accepted my gender identity.

1                      2                      3                      4                      5  
Strongly Disagree    Somewhat Disagree    Neither Agree nor Disagree    Somewhat Agree    Strongly Agree

## Affirmative Sexual Partner Scale

1. Considering your most recent sexual partner, what is their age?
  - 18-24 years old
  - 25-34 years old
  - 35-44 years old
  - 45-54 years old
  - 55-64 years old
  - 65-74 years old
  - 75 years or older
  
2. Considering your most recent sexual partner, which category or categories best represents their ethno-racial background?
  - Asian/Pacific Islander
  - Black or African American
  - Hispanic or Latino
  - Native American or American Indian
  - White
  - Other (please specify) \_\_\_\_\_
  
3. Considering your most recent sexual partner, which category best describes their gender identity?
  - Cisgender male
  - Cisgender female
  - Trans man or trans masculine
  - Trans woman or trans feminine
  - Non-binary/gender queer/agender
  - Other (please specify) \_\_\_\_\_
  
4. Considering your most recent sexual partner, which category best describes their sexual identity?
  - Asexual
  - Bisexual
  - Demisexual
  - Gay
  - Open/fluid
  - Pansexual
  - Queer
  - Straight/heterosexual
  - Other (please specify) \_\_\_\_\_

5. Considering your most recent sexual partner, what is/was the length of this relationship?

- Less than 6 months
- 6 months to 1 year
- 2 years to 5 years
- 5 to 10 years
- 10+ years

Please answer the following questions about your most recent sexual partner's role in affirming your gender identity:

1. My sexual partner makes me feel safe.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

2. There is something really special about the connection between my sexual partner and I.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

3. I feel that my sexual partner is physically attracted to me.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

4. My sexual partner physically and/or emotionally supports my gender identity.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

5. My sexual partner sees me as male or trans masculine

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

6. I receive positive feedback about my gender identity from my sexual partner.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

7. My sexual partner and I communicate about my sexual needs.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

8. My sexual partner regularly checks in on my sexual well-being.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

9. Communication about what feels comfortable or uncomfortable sexually happens on a regular basis.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree

10. I allow my sexual partner to touch dysphoric parts of my body in order to satisfy them.

1	2	3	4	5
Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree



11. Sometimes even if I am not in the mood, I engage in sexual activity to please my partner.
- |                   |                   |                            |                |                |
|-------------------|-------------------|----------------------------|----------------|----------------|
| 1                 | 2                 | 3                          | 4              | 5              |
| Strongly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Strongly Agree |
12. I find it easier to have sexual experiences with partners of certain sexual orientations over others. \_\_\_\_\_ (please specify) \_\_\_\_\_
- |                   |                   |                            |                |                |
|-------------------|-------------------|----------------------------|----------------|----------------|
| 1                 | 2                 | 3                          | 4              | 5              |
| Strongly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Strongly Agree |
13. I am less likely to engage in sexual activity with partners of certain sexual identities. \_\_\_\_\_ (please specify) \_\_\_\_\_
- |                   |                   |                            |                |                |
|-------------------|-------------------|----------------------------|----------------|----------------|
| 1                 | 2                 | 3                          | 4              | 5              |
| Strongly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Strongly Agree |
14. I worry what my sexual partner will think about my gender identity during sex.
- |                   |                   |                            |                |                |
|-------------------|-------------------|----------------------------|----------------|----------------|
| 1                 | 2                 | 3                          | 4              | 5              |
| Strongly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Strongly Agree |
15. I withhold discussing my sexual needs.
- |                   |                   |                            |                |                |
|-------------------|-------------------|----------------------------|----------------|----------------|
| 1                 | 2                 | 3                          | 4              | 5              |
| Strongly Disagree | Somewhat Disagree | Neither Agree nor Disagree | Somewhat Agree | Strongly Agree |

## The New Sexual Satisfaction Scale (NSSS)

Thinking about your most recent sexual experience, please rate your satisfaction with the following aspects:

Ego:

1. The intensity of my sexual arousal

1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied

2. The quality of my orgasms

1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied

3. My “letting go” and surrender to sexual pleasure during sex

1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied

4. My focus/concentration during sexual activity

1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied

5. The way I sexually react to my partner

1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied

6. My body’s sexual functioning

1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied

7. My emotional opening up in sex

1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied

8. My mood after sexual activity

1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied

9. The frequency of my orgasms

1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied

10. The pleasure I provide to my partner

1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied

Partner:

11. The balance between what I give and receive in sex

1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied

12. My partner's emotional opening up during sex	1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied	
13. My partner's initiation of sexual activity	1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied	
14. My partner's surrender to sexual pleasure ("letting go")	1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied	
15. The way my partner takes care of my sexual needs	1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied	
16. My partner's sexual creativity	1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied	
17. My partner's sexual availability	1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied	
18. The variety of my sexual activities	1	2	3	4	5
Not at all satisfied	A little satisfied	Moderately Satisfied	Very Satisfied	Extremely Satisfied	

#### Follow up Question

Do you feel that this survey accurately captured your experiences? If not, is there anything you would like to add? Please feel free to provide feedback.

## References

- Abdi, H. & Williams, L. J. (2010). Tukey's honestly significant difference (HSD) test. *Encyclopedia of Research Design. Thousand Oaks, CA: Sage*, 1-5. Retrieved from [https://www.researchgate.net/profile/Lynne\\_Williams/publication/237426041\\_Tukey's\\_Honestly\\_Signiflcant\\_Diference\\_HSD\\_Test/links/00463528e752ddb7f3000000.pdf](https://www.researchgate.net/profile/Lynne_Williams/publication/237426041_Tukey's_Honestly_Signiflcant_Diference_HSD_Test/links/00463528e752ddb7f3000000.pdf)
- Addison, S. M. & Coolhart, D. (2015). Expanding the therapy paradigm with queer couples: A relational intersectional lens. *Family Process, 54*(3), 435-453. doi: 10.1111/famp.12171.
- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.
- Amodeo, A. L., Vitelli, R., Scandurra, C., Picariello, S., & Valerio, P. (2015). Adult attachment and transgender identity in the Italian context: Clinical implications and suggestions for further research. *International Journal of Transgenderism, 16*, 49-61. doi: 10.1080/15532739.2015.1022680.
- Applegarth, G. & Nuttall, J. (2016). The lived experience of transgender people of talking therapies. *International Journal of Transgenderism, 17*(2), 66-72. doi: 10.1080/15532739.2016.1149540.
- Arbuckle, J. L. (2011). IBM® SPSS® Amos TM 20 Users Guide. *Chicago, IL: AMOS Development Corporation*.
- Armstrong, L. L. (2006). Barriers to intimate sexuality: Concerns and meaning-based therapy approaches. *The Humanistic Psychologist, 34*(3), 281-298. [https://doi.org/10.1207/s15473333thp3403\\_5](https://doi.org/10.1207/s15473333thp3403_5).

- Austin, A. & Goodman, R. (2017). The impact of social connectedness and internalized transphobic stigma on self-esteem among transgender and gender non-conforming adults. *Journal of Homosexuality*, 64(6), 825-841. doi: 10.1080/00918369.2016.1236587.
- Aydin, D., Buk, L. J., Partoft, S., Bonde, C., Thomsen, M. V., & Tos, T. (2016). Transgender surgery in Denmark from 1994 to 2015: 20-year follow-up study. *The Journal of Sexual Medicine*, 13(4), 720-725. <https://doi.org/10.1016/j.jsxm.2016.01.012>
- Bartolucci, C., Gómez-Gil, E., Salamero, M., Esteva, I., Guillamón, A., Zubiaurre, L., . . . & Montejo, A. L. (2015). Sexual quality of life in gender-dysphoric adults before genital sex reassignment surgery. *The Journal of Sexual Medicine*, 12(1), 180-188. <https://doi.org/10.1111/jsm.12758>
- Bauer, G. R., Redman, N., Bradley, K., & Scheim, A. I. (2013). Sexual health of trans men who are gay, bisexual, or who have sex with men: Results from Ontario, Canada. *International Journal of Transgenderism*, 14(2), 66-74. doi:10.1080/15532739.2013.791650.
- Becker, I., Auer, M., Barkmann, C., Fuss, J., Möller, B., Nieder, T. O., . . . & Richter-Appelt, H. (2018). A cross-sectional multicenter study of multidimensional body image in adolescents and adults with gender dysphoria before and after transition-related medical interventions. *Archives of Sexual Behavior*, 1-13. <https://doi.org/10.1007/s10508-018-1278-4>
- Becker, I., Nieder, T. O., Cerwenka, S., Briken, P., Kreukels, B. P. C., Cohen-Kettenis, P. T., . . . & Richter-Appelt, H. (2016). Body image in young gender dysphoric adults: A European multi-center study. *Archives of Sexual Behavior*, 45, 559-574. doi: 10.1007/s10508-015-0527-z.

- Benjamin, H. (1953). Transvestism and transsexualism. *International Journal of Sexology*, 7: 12-14. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5191737/>
- Benjamin, H. (1966). *The Transsexual Phenomenon*, New York: The Julian Press.
- Bennett, M., LoPresti, B. J., & Denes, A. (2019). Exploring trait affectionate communication and post sex communication as mediators of the association between attachment and sexual satisfaction. *Personality and Individual Differences*, 151, 109505.
- Bethea, M. S. & McCollum, E. E. (2013). The disclosure experiences of male-to-female transgender individuals: A systems theory perspective. *Journal of Couple & Relationship Therapy*, 12(2), 89-112. doi: 10.1080/15332691.2013.779094.
- Bettcher, T. M. (2014). When selves have sex: What the phenomenology of trans sexuality can teach about sexual orientation. *Journal of Homosexuality*, 61, 605-620. doi: 10.1080/00918369.2014.865472.
- Bliss, W. J. & Horne, S. G. (2005). Sexual satisfaction as more than a gendered concept: The roles of psychological well-being and sexual orientation. *Journal of Constructivist Psychology*, 18 (1), 25–38. doi: 10.1080/10720530590523044.
- Boughner, S. R., Mims, G. A., & Hecker, L. L. (2014). General systems theory, cybernetics, and family therapy. In *An Introduction to Marriage and Family Therapy* (pp. 63-84). Routledge.
- Bockting, W., Coleman, E., Deutsch, M. B., Guillamon, A., Meyer, I., Meyer III, W., . . . & Ettner, R. (2016). Adult development and quality of life of transgender and gender nonconforming people. *Current Opinion in Endocrinology, Diabetes, and Obesity*, 23(2), 188. doi: 10.0.1097/Med.0000000000000232.

- Bockting, W. O., Knudson, G., & Goldberg, J. M. (2006). Counseling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism*, 9(3-4), 35-82. [https://doi.org/10.1300/J485v09n03\\_03](https://doi.org/10.1300/J485v09n03_03)
- Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American Journal of Public Health*, 103(5), 943-951. Retrieved from <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2013.301241>
- Bowleg, L. (2013). "Once you've blended the cake, you can't take the parts back to the main ingredients": Black gay and bisexual men's descriptions and experiences of intersectionality. *Sex Roles*, 68(11-12), 754-767. doi: 10.1007/s11199-012-0152-4.
- Bowleg, L. (2008). When Black+ lesbian+ woman ≠ Black lesbian woman: The methodological challenges of qualitative and quantitative intersectionality research. *Sex roles*, 59(5-6), 312-325. doi: 10.1007/s11199-008-9400-z.
- Bowman, M. K. (2018). The Lived Experience of Transgender Individuals with Eating Disorders.
- Breslow, A. S., Brewster, M. E., Velez, B. L., Wong, S., Geiger, E., & Soderstrom, B. (2015). Resilience and collective action: Exploring buffers against minority stress for transgender individuals. *Psychology of Sexual Orientation and Gender Diversity*, 2(3), 253. <http://dx.doi.org/10.1037/sgd0000117>
- Brewster, M. E., Sandil, R., DeBlaere, C., Breslow, A., & Eklund, A. (2017). "Do you even lift, bro?" Objectification, minority stress, and body image concerns for sexual minority men. *Psychology of Men & Masculinity*, 18(2), 87. <http://dx.doi.org/10.1037/men0000043>

- Bridges, S. K., Lease, S. H., & Ellison, C. R. (2004). Predicting sexual satisfaction in women: Implications for counselor education and training. *Journal of Counseling and Development, 82* (2), 158–166. doi: 10.1002/j.1556-6678.2004.tb00297.x.
- Brody, S., & Weiss, P. (2011). Simultaneous penile–vaginal intercourse orgasm is associated with satisfaction (sexual, life, partnership, and mental health). *The journal of sexual medicine, 8*(3), 734-741.
- Brown, N. R. (2010). The sexual relationships of sexual-minority women partnered with trans men: A qualitative study. *Archives of Sexual Behavior, 39*(2), 561-572. doi:10.1007/s10508-009-9511-9.
- Brown, J. & Graham, D. (2008). Body satisfaction in gym-active males: An exploration of sexuality, gender, and narcissism. *Sex Roles, 59*(94), 94-106. doi: 10.1007/s11199-008-9416-4.
- Browne, M. W. & Cudeck, R. (1993). Alternative ways of assessing model fit. *Sage focus editions.*
- Byrne, B. M. (2016). Adaptation of assessment scales in cross-national research: Issues, guidelines, and caveats. *International Perspectives in Psychology: Research, Practice, Consultation, 5*(1), 51. <http://dx.doi.org/10.1037/ipp0000042>
- Buck, D. M. (2016). Defining transgender: What do lay definitions say about prejudice? *Psychology of Sexual Orientation and Gender Diversity, 3*(4), 465. <http://dx.doi.org/10.1037/sgd0000191>
- Bungener, S. L., Steensma, T. D., Cohen-Kettenis, P. T., & De Vries, A. L. (2017). Sexual and romantic experiences of transgender youth before gender-affirmative treatment. *Pediatrics, 139*(3), e20162283.



- Butler, J. (2006). Performative acts and gender constitution: An essay in phenomenology and feminist theory. In *The Routledge Falmer reader in gender & education* (pp. 73-83). Routledge.
- Campanile, D., Carlà-Uhink, F., & Facella, M. (Eds.). (2017). *TransAntiquity: Cross-Dressing and Transgender Dynamics in the Ancient World*. Taylor & Francis.
- Case, L. K., Brang, D., Landazuri, R., Viswanathan, P., & Ramachandran, V. S. (2017). Altered white matter and sensory response to bodily sensation in female-to-male transgender individuals. *Archives of Sexual Behavior*, *46*(5), 1223-1237. doi: 10.1007/s10508-016-0850-z
- Cauldwell, D.O. (1949b). Psychopathia transexualis. *Sexology*, *16*:274-280. Retrieved from <https://www.taylorfrancis.com/books/e/9780203955055/chapters/10.4324/9780203955055-11>
- Cava, P. (2016). Cisgender and cissexual. *The Wiley Blackwell encyclopedia of gender and sexuality studies*, 1-4. doi: 10.1002/9781118663219.wbegss131.
- Cerny, B. A., & Kaiser, H. F. (1977). A study of a measure of sampling adequacy for factor-analytic correlation matrices. *Multivariate behavioral research*, *12*(1), 43-47. [https://doi.org/10.1207/s15327906mbr1201\\_3](https://doi.org/10.1207/s15327906mbr1201_3)
- Chatterji, S., Bay-Cheng, L. Y., Schick, V., Dodge, B., Baldwin, A., Van Der Pol, B., & Fortenberry, J. D. (2017). The year's best: Interpersonal elements of bisexual women's most satisfying sexual experiences in the past year. *The Journal of Sex Research*, *54*(7), 887-898. <https://doi.org/10.1080/00224499.2016.1207056>

- Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: Journal of Women in Culture and Society*, 38(4), 785-810. <https://doi.org/10.1086/669608>
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., . . . & Monstrey, S. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism*, 13(4), 165-232. doi:10.1080/15532739.2011.700873.
- Colton Meier, S. L., Fitzgerald, K. M., Pardo, S. T., & Babcock, J. (2011). The effects of hormonal gender affirmation treatment on mental health in female-to-male transsexuals. *Journal of Gay & Lesbian Mental Health*, 15(3), 281-299. doi: 10.1080/19359705.2011.581195.
- Coolhart, D., Baker, A., Farmer, S., Malaney, M., & Shipman, D. (2013). Therapy with transsexual youth and their families: A clinical tool for assessing youth's readiness for gender transition. *Journal of Marital and Family Therapy*, 39(2), 223-243. doi: 10.1111/j.1752-0606.2011.00283.x.
- Coppola, J. L. (2019). *Emotional Bonds and Fairness Experiences between Transgender Women and Their Cisgender Partners: An Interpretative Phenomenological Exploration* (Doctoral dissertation, ProQuest Dissertations Publishing).
- Crenshaw, K. (2018). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics [1989]. In *Feminist legal theory* (pp. 57-80). Routledge.

- D'Arrigo-Patrick, J., Hoff, C., Knudson-Martin, C., & Tuttle, A. (2017). Navigating critical theory and postmodernism: Social justice and therapist power in family therapy. *Family Process, 56*(3), 574-588. doi: 10.1111/famp.12236.
- Daniel, S. & Bridges, S. K. (2013). The relationships among body image, masculinity, and sexual satisfaction in men. *Psychology of Men & Masculinity, 14*(4), 345-351. doi: 10.1037/a0029154.
- Davidmann, S. (2014). Imag(in)ing trans partnerships: Collaborative photography and intimacy. *Journal of Homosexuality, 61*(5), 636-653. doi: 10.1080/00918369.2014.865481.
- Davis, S. A. & Meier, S. C. (2014). Effects of testosterone treatment and chest reconstruction surgery on mental health and sexuality in female-to-male transgender people. *International Journal of Sexual Health, 26*, 113-128. doi: 10.1080/19317611.2013.833152.
- De Cuypere, G., T' Sjoen, G., Beerten, R., Selvaggi, G., De Sutter, P., Hoebeke, P..., & Rubens, R. (2005). Sexual and physical health after sex reassignment surgery. *Archives of Sexual Behavior, 34*(6), 679-690. doi: 10.1007/s10508-013-0140-y.
- De Savitsch, E. (1958). Homosexuality, transvestism and change of sex, London: Heinemann Medical Books.
- Devereux, G. (1937). Institutionalized homosexuality of the Mohave Indians. *Human Biology, 9*, 508-527. Retrieved from <https://search.proquest.com/docview/1301827597?pq-origsite=gscholar>

- Devor, H. (1993). Sexual orientation identities, attractions, and practices of female-to-male transsexuals. *The Journal of Sex Research, 30*(4), 303-315. <https://doi.org/10.1080/00224499309551717>
- dickey, l. m., Burnes, T. R., & Singh, A. A. (2012). Sexual identity development of female-to-male transgender individuals: A grounded theory inquiry. *Journal of LGBT Issues in Counseling, 6*(2), 118-138. doi: 10.1080/15538605.2012.678184.
- Doorduyn, T. & Van Berlo, W. (2014). Trans people's experience of sexuality in the Netherlands: A pilot study. *Journal of Homosexuality, 61*(5), 654-672. doi: 10.1080/00918369.2014.865482.
- Dozier, R. (2005). Beards, breasts, and bodies: Doing sex in a gendered world. *Gender & Society, 19*(3), 297-316. doi: 10.1177/0891243204272153.
- Edelman, E. A. & Zimman, L. (2014). Boycunts and bonus holes: Trans men's bodies, neoliberalism, and the sexual productivity of genitals. *Journal of homosexuality, 61*(5), 673-690. doi: 10.1080/00918369.2014.870438.
- Ehrensaft, D., Keo-Meier, C. L., & Yuen, J. (2019). Transition Considerations for Transgender Patients. In *Transitioning from Pediatric to Adult Care in Endocrinology* (pp. 195-219). Springer, Cham.
- Ekins, R. & King, D. (2001). Pioneers of transgenering: The popular sexology of David O. Cauldwell. *International Journal of Transgenderism, 5*(2), 97-03. Retrieved from [https://cdn.atria.nl/eazines/web/IJT/97-03/numbers/symposion/cauldwell\\_01.htm](https://cdn.atria.nl/eazines/web/IJT/97-03/numbers/symposion/cauldwell_01.htm)
- Fahs, B. (2014). Coming to power: Women's fake orgasms and best orgasm experiences illuminate the failures of (hetero) sex and the pleasures of connection. *Culture, Health & Sexuality, 16*(8), 974-988. doi: 10.1080/13691058.2014.924557.

- Fisk, N. (1974). Gender dysphoria syndrome: The conceptualization that liberalizes indications for total gender reorientation and implies a broadly based multi-dimensional rehabilitative regimen. *Western Journal of Medicine*, 120, 386–391. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1130142/>
- Floyd, F. J. & Widaman, K. F. (1995). Factor analysis in the development and refinement of clinical assessment instruments. *Psychological Assessment*, 7(3), 286. <http://dx.doi.org.libezproxy2.syr.edu/10.1037/1040-3590.7.3.286>
- Frost, D. M. & Meyer, I. H. (2009). Internalized homophobia and relationship quality among lesbians, gay men, and bisexuals. *Journal of Counseling Psychology*, 56(1), 97. doi: 10.1037/a0012844
- Galupo, M. P., Henise, S. B., & Mercer, N. L. (2016). “The labels don't work very well”: Transgender individuals' conceptualizations of sexual orientation and sexual identity. *International Journal of Transgenderism*, 17(2), 93-104. <https://doi.org/10.1080/15532739.2016.1189373>.
- Galupo, M. P. & Orphanidys, J. C. (2018) Special issue of International Journal of Transgenderism: Transgender people of color and intersections of oppression, *International Journal of Transgenderism*, 19:1, 113-113. doi: 10.1080/15532739.2018.1459246.
- Gamarel, K. E., Reisner, S. L., Laurenceau, J. P., Nemoto, T., & Operario, D. (2014). Gender minority stress, mental health, and relationship quality: A dyadic investigation of transgender women and their cisgender male partners. *Journal of Family Psychology*, 28(4), 437. <http://dx.doi.org/10.1037/a0037171>

- Gil, S. (2007). Body image, well-being and sexual satisfaction: A comparison between heterosexual and gay men. *Sexual and Relationship Therapy, 22*(2), 237-244. doi: 10.1080/14681990600855042.
- Green, J. (2005). Part of the package: Ideas of masculinity among male-identified transpeople. *Men and Masculinities, 7*(3), 291-299. doi: 10.1177/1097184X04272116.
- Green, R. J. & Mitchell, V. (2015). Gay, lesbian, and bisexual issues in couple therapy. In A. S. Gurman, J. L. Lebow, & D. K. Snyder (Eds.), *Clinical Handbook of Couple Therapy*, 5th ed. New York: Guilford
- Hale, C. J. (1997). Leatherdyke boys and their daddies: How to have sex without women or men. *Queer Transxions of Race, Nation, and Gender, 52/53*, 223-236. doi: 10.2307/466741.
- Hansbury, G. (2017). The Masculine Vaginal: Working With Queer Men's Embodiment at the Transgender Edge. *Journal of the American Psychoanalytic Association, 65*(6), 1009-1031. doi: 10.1177/0003065117742409.
- Harris, S. M. & Hays, K. W. (2008). Family therapist comfort with and willingness to discuss client sexuality. *Journal of Marital and Family Therapy, 34*(2), 239-250. doi: 10.1111/j.1752-0606.2008.00066.x.
- Hart, A. (1935). *Doctor Mallory*. W. W. Norton & Company, Inc. Retrieved from <https://www.worldcat.org/title/doctor-mallory/oclc/8502872>
- Hausman, B. L. (2001). Recent transgender theory. *Feminist Studies, 27*(2), 465-490. Retrieved from <https://www.jstor.org/stable/3178770>
- Hayes, A. F. (2012). PROCESS: A versatile computational tool for observed variable mediation, moderation, and condition process modeling. Retrieved from <http://www.afhayes.com/public/process2012.pdf>

- Hayes, A. F., Montoya, A. K., & Rockwood, N. J. (2017). The analysis of mechanisms and their contingencies: PROCESS versus structural equation modeling. *Australasian Marketing Journal (AMJ)*, 25(1), 76-81. <https://doi.org/10.1016/j.ausmj.2017.02.001>
- Hayes, A. F. (2018). Introduction to mediation, moderation, and conditional process analysis second edition: A regression-based approach. New York, NY: Guilford Publications.
- Hendricks, M. L. & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. *Professional Psychology: Research and Practice*, 43(5), 460. doi: 10.1037/a0029597.
- Herek, G. M. (2007). Confronting sexual stigma and prejudice: Theory and practice. *Journal of Social Issues*, 63(4), 905-925. doi: 10.1111/j.1540-4560.2007.00544.x
- Hidalgo, M. A., Ehrensaft, D., Tishelman, A. C., Clark, L. F., Garofalo, R., Rosenthal, S. M., . . . & Olson, J. (2013). The gender affirmative model: What we know and what we aim to learn. *Human Development*, 56(5), 285-290. doi: 10.1159/000355235.
- Hirschfeld, M. (1910, trans 1991) *Transvestites: The Erotic Drive to Cross-Dress*, New York: Prometheus Books.
- Hirschfeld, M. (1923) Die intersexuelle konstitution. *Jahrbuch fuer sexuelle Zwischenstufen*, 23: 3-27.
- Holmberg, M., Arver, S., & Dhejne, C. (2018). Supporting sexuality and improving sexual function in transgender persons. *Nature Reviews Urology*, 1. doi: 10.1038/s41585-018-0108-8.

- Holmberg, D. & Blair, K. L. (2009). Sexual desire, communication, satisfaction, and preferences of men and women in same-sex versus mixed-sex relationships. *Journal of Sex Research, 46*(1), 57-66. doi: 10.1080/00224490802645294.
- Hooper, T., Redmayne, E., Vikander, A., Wishaw, B., Ebershoff, D., . . . Working Title Films. (2016). *The Danish girl*. Universal City, CA: Universal Studios Home Entertainment.
- Iantaffi, A. & Benson, K. (2018). Sex is for every body: Trans-affirming sex therapy In D. Flemons & S. Green (Eds.). *Quickies: The Handbook of Brief Sex Therapy*. (pp. 196-215). New York, NY: WW Norton & Company.
- Iantaffi, A. & Bockting, W. O. (2011). Views from both sides of the bridge? Gender, sexual legitimacy and transgender people's experiences of relationships. *Culture, Health & Sexuality, 13*(3), 355-370. doi: 10.1080/13691058.2010.537770.
- Irwig, Michael S. "Testosterone therapy for transgender men." *The lancet Diabetes & endocrinology 5.4* (2017): 301-311.
- James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality.
- Johnson, S. M. & Zuccarini, D. (2011). EFT for sexual issues: An integrated model of couple and sex therapy. *The Emotionally Focused Casebook: New Directions in Treating Couples* (2011): 219-246.
- Jones, A. C., Robinson, W. D., & Seedall, R. B. (2018). The role of sexual communication in couples' sexual outcomes: A dyadic path analysis. *Journal of Marital and Family Therapy, 44*(4), 606-623. doi: 10.1111/jmft.12282.



- Joslin-Roher, E. & Wheeler, F. P. (2009). Partners in transition: The transition experience of lesbian, bisexual, and queer identified partners of transgender men. *Journal of Gay & Lesbian Social Services, 21*(1), 30-48. doi: 10.1080/10538720802494743.
- Kaestle, C. E. & Halpern, C. T. (2007). What's love got to do with it? Sexual behaviors of opposite-sex couples through emerging adulthood. *Perspectives on Sexual and Reproductive Health, 39*(3), 134-140. doi: 10.1363/3913407.
- Kaiser, H. F. (1960). The application of electronic computers to factor analysis. *Educational and Psychological Measurement, 20*(1), 141-151. <http://dx.doi.org.libezproxy2.syr.edu/10.1177/0013164460020000116>
- Kim, H. Y. (2013). Statistical notes for clinical researchers: assessing normal distribution (2) using skewness and kurtosis. *Restorative Dentistry & Endodontics, 38*(1), 52-54. <https://doi.org/10.5395/rde.2013.38.1.52>
- Kline, R. B. (2013). Exploratory and confirmatory factor analysis. Applied quantitative analysis in the social sciences, 171-207. Retrieved from <https://psychology.concordia.ca/fac/kline/efa&cfa.html>
- Kline, C & Gorzalska, B. B. (2009). Sexual functioning in transsexuals following hormone therapy and genital surgery: A review. *Journal of Sexual Medicine, 6*, 2922-2939. doi: 10.1111/j.1743-6109.2009.01370x
- Kozee, H. B., Tylka, T. L., & Bauerband, L. A. (2012). Measuring transgender individuals' comfort with gender identity and appearance: Development and validation of the Transgender Congruence Scale. *Psychology of Women Quarterly, 36*(2), 179-196. <https://doi.org/10.1177/0361684312442161>

- Kuyper, L. & Wijsen, C. (2014). Gender identities and gender dysphoria in the Netherlands. *Archives of sexual behavior*, *43*(2), 377-385. doi: 10.1007/s10508-013-0140-y.
- Langer, S. (2014). Our body project: From mourning to creating the transgender body. *International Journal of Transgenderism* (15), 66-75. doi: 10.1080/15532739.2014.899175.
- Latham, J. R. (2016). Trans men's sexual narrative-practices: Introducing STS to trans and sexuality studies. *Sexualities*, *19*(3), 347-368. <https://doi.org/10.1177/1363460715583609>
- Laumann, E. O., Nicolosi, A., Glasser, D. B., Paik, A., Gingell, C., Moreira, E., & Wang, T. (2005). Sexual problems among women and men aged 40–80 y: prevalence and correlates identified in the Global Study of Sexual Attitudes and Behaviors. *International journal of impotence research*, *17*(1), 39.
- Leech, N. L., Barrett, K. C., & Morgan, G. A. (2015). Factorial ANOVA and ANCOVA In. *IBM SPSS for Intermediate Statistics: Use and Interpretation*. New York, NY: Routledge.
- Leiblum, S. R. (2007). Sex therapy today, current issues and future perspectives. In S. Lieblum (Ed.), *Principles and practice of sex therapy* (4th ed., pp. 3–25). New York: Guilford Press.
- Leit, R. A., Gray, J. J., & Pope Jr, H. G. (2002). The media's representation of the ideal male body: A cause for muscle dysmorphia?. *International Journal of Eating Disorders*, *31*(3), 334-338.
- Lev, A. I. (2018). Understanding transgender identities and exploring sexuality and desire. In Allez, G. H. (Ed). *Sexual Diversity and Sexual Offending*. Research, Assessment and Clinical Treatment in Psychosexual Therapy. London: Karnac.

- Lev, A. I. (2006). Disordering gender identity: Gender identity disorder in the DSM-IV-TR. *Journal of Psychology & Human Sexuality*, 17(3-4), 35-69. [https://doi.org/10.1300/J056v17n03\\_03](https://doi.org/10.1300/J056v17n03_03)
- Lev, A. I. (2004). *Transgender emergence*. New York, NY: Haworth Clinical Practice Press.
- Lev, A. I. & Sennott, S. (2012). Trans-sexual desire in different gendered bodies. In J. J. Bigner & J. L. Wetcher (Eds.), *Handbook of LGBT-Affirmative Couple and Family Therapy* (pp.113-127). New York: Taylor & Francis.
- Lindroth, M., Zeluf, G., Mannheimer, L. N., & Deogan, C. (2017). Sexual health among transgender people in Sweden. *International Journal of Transgenderism*, 18(3), 318-327. <https://doi.org/10.1080/15532739.2017.1301278>
- Macapagal, K., Greene, G. J., Rivera, Z., & Mustanski, B. (2015). “The best is always yet to come”: Relationship stages and processes among young lgbt couples. *Journal of Family Psychology*, 29(3), 309-320. <http://dx.doi.org/10.1037/fam0000094>
- Mark, K. P. & Jozkowski, K. N. (2013). The mediating role of sexual and nonsexual communication between relationship and sexual satisfaction in a sample of college-age heterosexual couples. *Journal of Sex & Marital Therapy*, 39(5), 410-427. doi:10.1080/0092623X.2011.644652.
- Martin, T.K. & Coolhart, D. (2019). “Because your dysphoria gets in the way of you...it affects everything.” The mental, physical, and relational aspects of navigating body dysphoria and sex for trans masculine people. *Journal of Sexual and Relationship Therapy*. doi: 10.1080/14681994.2019.1696459
- Masters, W. H., & Johnson, V. E. (1970). *Human sexual inadequacy* (Vol. 225). Boston: Little, Brown.

- Matsuno, E., & Budge, S. L. (2017). Non-binary/genderqueer identities: A critical review of the literature. *Current Sexual Health Reports*, 9(3), 116-120. doi: 10.1007/s11930-017-0111-8.
- McClelland, S. I. (2010). Intimate justice: A critical analysis of sexual satisfaction. *Social and Personality Psychology Compass*, 4(9), 663-680. doi: 10.1111/j.1751-9004.2010.00293.x.
- McClelland, S. I. (2014). "What do you mean when you say that you are sexually satisfied?" A mixed methods study. *Feminism & Psychology*, 24(1), 74-96. <https://doi.org/10.1177/0959353513508392>
- McGeorge, C. & Stone Carlson, T. (2011). Deconstructing heterosexism: Becoming an LGB affirmative heterosexual couple and family therapist. *Journal of Marital and Family Therapy*, 37(1), 14-26. doi: 10.1111/j.1752-0606.2009.00149.x.
- McInroy, L. B. & Craig, S. L. (2015). Transgender representation in offline and online media: LGBTQ youth perspectives. *Journal of Human Behavior in the Social Environment*, 25(6), 606-617. doi: 10.1080/10911359.2014.995392.
- McLemore, K. A. (2015). Experiences with misgendering: Identity misclassification of transgender spectrum individuals. *Self and Identity*, 14(1), 51-74. doi:10.1080/15298868.2014.950691.
- Meier, S. C., Sharp, C., Michonski, J., Babcock, J. C., & Fitzgerald, K. (2013). Romantic relationships of female-to-male trans men: A descriptive study. *International Journal of Transgenderism*, 14(2), 75-85. doi: 10.1080/15532739.2013.791651.
- Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior*, 38. doi: 10.2307/2137286.

- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674. doi: 10.1037/0033-2909.129.5.674.
- Meyer, I. H. (2015). Resilience in the study of minority stress and health of sexual and gender minorities. *Psychology of Sexual Orientation and Gender Diversity*, *2*(3), 209. <http://dx.doi.org/10.1037/sgd0000132>
- Meyerowitz, J. (1998). Sex change and the popular press: Historical notes on transsexuality in the United States, 1930–1955. *GLQ: A Journal of Lesbian and Gay Studies*, *4*(2), 159–187. Retrieved from <https://norek.pw/sexchangeandthepopular.pdf>
- Milhausen, R. R., Buchholz, A. C., Opperman, E. A., & Benson, L. E. (2015). Relationships between body image, body composition, sexual functioning, and sexual satisfaction among heterosexual young adults. *Archives of Sexual Behavior*, *44*(6), 1621–1633. doi: 10.1007/s10508-014-0328-9.
- Mizock, L. & Hopwood, R. (2016). Conflation and interdependence in the intersection of gender and sexuality among transgender individuals. *Psychology of Sexual Orientation and Gender Diversity*, *3*(1), 93–103. <http://dx.doi.org/10.1037/sgd0000157>
- Moradi, B., Tebbe, E. A., Brewster, M. E., Budge, S. L., Lenzen, A., Ege, E., ... & Hiner, D. L. (2016). A content analysis of literature on trans people and issues: 2002–2012. *The Counseling Psychologist*, *44*(7), 960–995. doi: 10.1177/0011000015609044.
- Murray, S. L., & Holmes, J. G. (1997). A leap of faith? Positive illusions in romantic relationships. *Personality and Social Psychology Bulletin*, *23*(6), 586–604. Retrieved from <https://journals.sagepub.com/doi/pdf/10.1177/0146167297236003>

- Nagoshi, J. L. & Brzuzy, S. (2010). Transgender theory: Embodying research and practice. *Journal of Women and Social Work, 25*(4), 431-443. doi: 10.1177/0886109910384068.
- Newsom. Exploratory and Confirmatory Factor Analysis. 2017. Retrieved from <https://web.pdx.edu/~newsomj/pmclass/EFA%20and%20CFA.pdf>. PowerPoint Presentation.
- Nikkelen, S. W. & Kreukels, B. P. (2018). Sexual experiences in transgender people: the role of desire for gender-confirming interventions, psychological well-being, and body satisfaction. *Journal of Sex & Marital Therapy, 44*(4), 370-381. doi: 10.1080/0092623X.2017.1405303.
- Otis, M. D., Rostosky, S. S., Riggle, E. D., & Hamrin, R. (2006). Stress and relationship quality in same-sex couples. *Journal of Social and Personal Relationships, 23*(1), 81-99. doi: 10.1177/0265407506060179.
- Pascoal, P. M., Narciso, I. D. S. B., & Pereira, N. M. (2014). What is sexual satisfaction? Thematic analysis of lay people's definitions. *Journal of sex research, 51*(1), 22-30. doi: 10.1080/00224499.2013.815149.
- Pfeffer, C. A. (2008) Bodies in relation-bodies in transition: Lesbian partners of trans men and body image. *Journal of Lesbian Studies, 12*(4). doi: 10.1080/10894160802278184.
- Pfeffer, C. A. (2017). *Queering families: The postmodern partnerships of cisgender women and transgender men*. Oxford University Press.
- Pflum, S. R., Testa, R. J., Balsam, K. F., Goldblum, P. B., & Bongar, B. (2015). Social support, trans community connectedness, and mental health symptoms among transgender and gender nonconforming adults. *Psychology of Sexual Orientation and Gender Diversity, 2*(3), 281. <http://dx.doi.org/10.1037/sgd0000122>

- Phillips, L. & Stewart, M. R. (2008). "I am just so glad you are alive": New perspectives on non-traditional, non-conforming, and transgressive expressions of gender, sexuality, and race among African Americans. *Journal of African American Studies*, 12(4), 378. doi:10.1007/s12111-008-9053-6.
- Platt, L. F. & Bolland, K. S. (2018). Relationship partners of transgender individuals: A qualitative exploration. *Journal of Social and Personal Relationships*, 35(9), 1251-1272. doi: 10.1177 /0265407517709360.
- Plummer, K. (2005). Male sexualities. *Handbook of Studies on Men and Masculinities*, 178-195. Retrieved from <https://kenplummer.com/publications/selected-writings-2/male-sexualities/>
- Preston, M. (2012). Not another special guest: Transgender inclusivity in a human sexuality course. *The Radical Teacher*, (92), 47-54. doi: 10.5406/radicalteacher.92.0047.
- Pulice-Farrow, L., Brown, T. D., & Galupo, M. P. (2017). Transgender microaggressions in the context of romantic relationships. *Psychology of Sexual Orientation and Gender Diversity*, 4(3), 362. <http://dx.doi.org/10.1037/sgd0000238>
- Rachlin, K., Hansbury, G., Pardo, S. T. (2010). Hysterectomy and oophorectomy experiences of female-to-male transgender individuals. *International Journal of Transgenderism*, 12, 155-166. doi: 10.1080/15532739.2010.514220.
- Raj, R. (2002). Towards a transpositive therapeutic model: Developing clinical sensitivity and cultural competence in the effective support of transsexual and transgendered clients. *International Journal of Transgenderism*, 6(2), 1553-2739. Retrieved from <https://psycnet.apa.org/record/2003-03459-004>

- Ramachandran, V. S. & McGeoch, P. D. (2008). Phantom penises in transsexuals. *Journal of Consciousness Studies*, 15(1), 5-16. Retrieved from <https://www.ingentaconnect.com/content/imp/jcs/2008/00000015/00000001/art00001>
- Regan, P. C., Levin, L., Sprecher, S., Christopher, F. S., & Gate, R. (2000). Partner preferences: What characteristics do men and women desire in their short-term sexual and long-term romantic partners?. *Journal of Psychology & Human Sexuality*, 12(3), 1-21.
- Riley Snorton, C. (2017). *Black on both sides: A racial history of trans identity*. Minneapolis, MN: University of Minnesota Press.
- Ritter, K., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. New York, NY: Guilford Press.
- Rodgers, R. F., Paxton, S. J., & McLean, S. A. (2014). A biopsychosocial model of body image concerns and disordered eating in early adolescent girls. *Journal of youth and adolescence*, 43(5), 814-823.
- Rood, B. A., Reisner, S. L., Puckett, J. A., Surace, F. I., Berman, A. K., & Pantalone, D. W. (2017). Internalized transphobia: Exploring perceptions of social messages in transgender and gender-nonconforming adults. *International Journal of Transgenderism*, 18(4), 411-426. <https://doi.org/10.1080/15532739.2017.1329048>
- Rowniak, S. & Chesla, C. (2013). Coming out for a third time: Transmen, sexual orientation and identity. *Archives of Sexual Behavior*, 42, 449-461. doi: 10.1007/s10508-012-0036-2.
- Rubin, H. (2003). *Self-made men: Identity and embodiment among transsexual men*. Vanderbilt University Press.
- Rutter, P. A., Leech, N. N., Anderson, M., & Saunders, D. (2010). Couples counseling for a transgender-lesbian couple: Student counselors' comfort and discomfort with sexuality



- counseling topics. *Journal of GLBT Family Studies*, 6(1), 68-79. <https://doi.org/10.1080/15504280903472816>
- Sanchez, D. T., Crocker, J., & Boike, K. R. (2005). Doing gender in the bedroom: Investing in gender norms and the sexual experience. *Personality and Social Psychology Bulletin*, 31(10), 1445-1455. Retrieved from <https://journals.sagepub.com/doi/pdf/10.1177/0146167205277333>
- Sanchez, D. T. & Kiefer, A. K. (2007). Body concerns in and out of the bedroom: Implications for sexual pleasure and problems. *Archives of Sexual Behavior*, 36(6), 808-820. doi: 10.1007/s10508-007-9205-0.
- Sanz, V. (2017). No Way Out of the Binary: A Critical History of the Scientific Production of Sex. *Signs: Journal of Women in Culture and Society*, 43(1), 1-27. <https://doi.org/10.1086/692517>
- Schippers, M. (2007). Recovering the feminine other: Masculinity, femininity, and gender hegemony. *Theory and Society*, 36(1), 85-102. doi: 10.1007/s11186-007-9022-4.
- Schwartz, P. & Young, L. (2009). Sexual satisfaction in committed relationships. *Sexuality Research & Social Policy*, 6(1), 1-17. Retrieved from <https://link.springer.com/content/pdf/10.1525%2Fsrsp.2009.6.1.1.pdf>
- Scandurra, C., Amodeo, A. L., Bochicchio, V., Valerio, P., & Frost, D. M. (2017). Psychometric characteristics of the Transgender Identity Survey in an Italian sample: A measure to assess positive and negative feelings towards transgender identity. *International Journal of Transgenderism*, 18(1), 53-65. <https://doi.org/10.1080/15532739.2016.1241975>

- Scandurra, C., Amodeo, A. L., Valerio, P., Bochicchio, V., & Frost, D. M. (2017). Minority stress, resilience, and mental health: A study of Italian transgender people. *Journal of Social Issues*, 73(3), 563-585. doi: 10.1111/josi.12232.
- Schilt, K. & Windsor, E. (2014). The sexual habitus of transgender men: negotiating sexuality through gender. *Journal of Homosexuality*, 62, 732-748. doi:10.1080/00918369.2014.870444.
- Schleifer, D. (2006). Make me feel mighty real: Gay female-to-male transgenderists negotiating sex, gender, and sexuality. *Sexualities*, 9(1), 57-75. doi: 10.1177/1363460706058396.
- Schooler, D. & Ward, L. M. (2006) Average Joes: Men's relationships with media, real bodies, and sexuality. *Psychology of Men & Masculinity*, 7(1), 27-41. doi: 10.1037/1524-9220.7.1.27.
- Sennett, J. (Ed.). (2006). *Self-organizing men: Conscious masculinities in time and space*. Ypsilanti, MI: Homofactus Press.
- Serano, J. (2016). *Whipping girl: A transsexual woman on sexism and the scapegoating of femininity*. Hachette UK.
- Shipman, D., & Martin, T. (2019). Clinical and Supervisory Considerations for Transgender Therapists: Implications for Working with Clients. *Journal of marital and family therapy*, 45(1), 92-105.
- Sigusch, V. (1991). Die Transsexuellen und unser nosomorpher Blick. Teil I: Zur Enttotalisierung des Transsexualismus. Teil II: Zur Entpathologisierung des Transsexualismus. *Z. Sexualforsch*, 4, 225-256.

- Skinta, M. D., Hoeflein, B., Muñoz-Martínez, A. M., & Rincón, C. L. (2018). Responding to gender and sexual minority stress with functional analytic psychotherapy. *Psychotherapy, 55*(1), 63. <http://dx.doi.org/10.1037/pst0000157>
- Slabbekoorn, D., Van Goozen, S. H., Gooren, L. J., & Cohen-Kettenis, P. T. (2001). Effects of cross-sex hormone treatment on emotionality in transsexuals. *International Journal of Transgenderism, 5*(3). Retrieved from [https://cdn.atria.nl/ezines/web/IJT/97-03/numbers/symposium/ijtvo05no03\\_02.htm](https://cdn.atria.nl/ezines/web/IJT/97-03/numbers/symposium/ijtvo05no03_02.htm)
- Spencer, K. G., Iantaffi, A., & Bockting, W. (2017). Treating sexual issues in transgender clients. *The Wiley Handbook of Sex Therapy, 291*.
- Spencer, K. G. & Vencill, J. A. (2017). Body beyond: A pleasure-based, sex-positive group therapy curriculum for transfeminine adults. *Psychology of Sexual Orientation and Gender Diversity, 4*(4), 392. <http://dx.doi.org/10.1037/sgd0000248>
- Starks, T. J., Grov, C., & Parsons, J. T. (2013). Sexual compulsivity and interpersonal functioning: Sexual relationship quality and sexual health in gay relationships. *Health Psychology, 32*(10), 1047-1056. <http://dx.doi.org/10.1037/a0030648>
- Stephenson, R., Riley, E., Rogers, E., Suarez, N., Metheny, N., Senda, J., . . . & Bauermeister, J. A. (2017). The sexual health of transgender men: a scoping review. *The Journal of Sex Research, 54*(4-5), 424-445. <https://doi.org/10.1080/00224499.2016.1271863>
- Strelan, P. & Hargreaves, D. (2005). Reasons for exercise and body esteem: Men's responses to self-objectification. *Sex Roles, 53*(7-8), 495-503. doi: 10.1007/s11199-005-7137-5.
- Štulhofer, A., Buško, V., & Brouillard, P. (2010). Development and bicultural validation of the new sexual satisfaction scale. *Journal of Sex Research, 47*(4), 257-268. doi: 10.1007/s11199-005-7137-5.

- Štulhofer, A., Ferreira, L. C., & Landripet, I. (2014). Emotional intimacy, sexual desire, and sexual satisfaction among partnered heterosexual men. *Sexual and Relationship Therapy, 29*(2), 229-244. doi: 10.1080/14681994.2013.870335.
- Sylvia. (2015, March 14). A short history of gender dysphoria. Retrieved from <https://www.susans.org/2015/03/03/gender-dysphoria-a-trip-down-memory-lane/>
- Testa, R. J., Habarth, J., Peta, J., Balsam, K., & Bockting, W. (2015). Development of the gender minority stress and resilience measure. *Psychology of Sexual Orientation and Gender Diversity, 2*(1), 65. <http://dx.doi.org/10.1037/sgd0000081>
- Testa, R. J., Michaels, M. S., Bliss, W., Rogers, M. L., Balsam, K. F., & Joiner, T. (2017). Suicidal ideation in transgender people: Gender minority stress and interpersonal theory factors. *Journal of Abnormal Psychology, 126*(1), 125. <http://dx.doi.org/10.1037/abn0000234>
- Theron, L. & Collier, K. L. (2013). Experiences of female partners of masculine-identifying trans persons. *Culture, Health & Sexuality, 15*(sup1), 62-75. doi: 10.1080/13691058.2013.788214.
- Thurston, M. D. & Allan, S. (2018). Sexuality and sexual experiences during gender transition: A thematic synthesis. *Clinical psychology review, 66*, 39-50. <https://doi.org/10.1016/j.cpr.2017.11.008>
- Tiefer, L. (2001). A new view of women's sexual problems: Why new? Why now? <https://doi.org/10.1080/00224490109552075>
- Timm, T.M. (2009). “Do I really have to talk about sex?” Encouraging beginning therapists to integrate sexuality into couple therapy. *Journal of Couple & Relationship Therapy, 8*(1), 15-33. doi: 10.1080/15332690802626692.

- Timmins, L., Rimes, K. A., & Rahman, Q. (2017). Minority stressors and psychological distress in transgender individuals. *Psychology of Sexual Orientation and Gender Diversity, 4*(3), 328. <http://dx.doi.org/10.1037/sgd0000237>
- Transgender Law Center (2019). Retrieved from <https://transgenderlawcenter.org/resources/id>
- Tree-McGrath, C. A. F., Puckett, J. A., Reisner, S. L., & Pantalone, D. W. (2018). Sexuality and gender affirmation in transgender men who have sex with cisgender men. *International Journal of Transgenderism, 1-12*. <https://doi.org/10.1080/15532739.2018.1463584>
- Tobin, H. J. (2003, April). *Sexuality in Transsexual and Transgender Individuals*. Honors Thesis in Sociology, Oberlin College. Retrieved from <https://sites.google.com/site/hjtobin/Home/thesis-index>.
- Turan, Ş., Poyraz, C. A., Sağlam, N. G. U., Demirel, Ö. F., Haliloğlu, Ö., Kadioğlu, P., & Duran, A. (2018). Alterations in body uneasiness, eating attitudes, and psychopathology before and after cross-sex hormonal treatment in patients with female-to-male gender dysphoria. *Archives of Sexual Behavior, 1-13*. <https://doi.org/10.1007/s10508-018-1189-4>
- Van, M. R. (2004). Thoughts on transcending stone: The tale of one transgendered man and his journey to find sexuality in his new skin In M. Diamond (Ed.), *From the Inside Out: Radical Gender Transformations, FTM and Beyond* (pp. 53-55). San Francisco, CA: Manic D. Press.
- van den Brink, F., Vollmann, M., Smeets, M. A., Hessen, D. J., & Woertman, L. (2018). Relationships between body image, sexual satisfaction, and relationship quality in romantic couples. *Journal of Family Psychology, 32*(4), 466. <http://dx.doi.org/10.1037/fam0000407>

- van de Grift, T. C., Kreukels, B. P. C., Elfering, L., Ozer, M., Bouman, M., Buncamper, M. E., Smit, J. M., & Mullenger, M. G. (2016). Body image in transmen: Multidimensional measurement and the effects of mastectomy. *The Journal of Sexual Medicine, 13*, 1778-1786. <http://dx.doi.org.libezproxy2.syr.edu/10.1016/j.jsxm.2016.09.003>
- van de Grift, T. C., Pigot, G. L., Boudhan, S., Elfering, L., Kreukels, B. P., Gijs, L. A., . . . & Bouman, M. B. (2017). A longitudinal study of motivations before and psychosexual outcomes after genital gender-confirming surgery in transmen. *The Journal of Sexual Medicine, 14*(12), 1621-1628. <https://doi.org/10.1016/j.jsxm.2017.10.064>
- van de Grift, T. C., Pigot, G. L., Kreukels, B. P., Bouman, M. B., & Mullender, M. G. (2019). Transmen's experienced sexuality and genital gender-affirming surgery: Findings from a clinical follow-up study. *Journal of Sex & Marital Therapy, 1-5*. doi: 10.1080/0092623X.2018.1500405
- Velez, B. L., Breslow, A. S., Brewster, M. E., Cox, R., & Foster, A. B. (2016). Building a pantheoretical model of dehumanization with transgender men: Integrating objectification and minority stress theories. *Journal of Counseling Psychology 63*(5), 497-508. <http://dx.doi.org.libezproxy2.syr.edu/10.1037/cou0000136>
- Von Bertalanffy, L. (1968). General system theory. *New York, 41973*(1968), 40.
- Walsh, F. (2012). The new normal: Diversity and complexity in 21st-century families. In F. Walsh (Ed.), *Normal family processes: Growing diversity and complexity*. New York, NY: The Guilford Press.
- Wiederman, M. W. (2005). The gendered nature of sexual scripts. *The Family Journal, 13*(4), 496-502. doi: 10.1177/1066480705278729.

- Wierckx, K., Elaut, E., Van Caenegem, E., Van De Peer, F., Dedecker, D., Van Houdenhove, E., & T'Sjoen, G. (2011). Sexual desire in female-to-male transsexual persons: exploration of the role of testosterone administration. *European Journal of Endocrinology*, *165*(2), 331-337.
- Wierckx, K., Elaut, E., Van Hoorde, B., Heylens, G., De Cuypere, G., Monstrey, S., . . . & T'sjoen, G. (2014). Sexual desire in trans persons: associations with sex reassignment treatment. *The Journal of Sexual Medicine*, *11*(1), 107-118. <https://doi.org/10.1111/jsm.12365>
- Williams, C. J., Weinberg, M. S., & Rosenberger, J. G. (2013). Trans men: Embodiments, identities, and sexualities. In *Sociological Forum*, *28*(4), 719-741. doi: 10.1111/socf.12056.
- Woertman, L. & Van den Brink, F. (2012). Body image and female sexual functioning and behavior: a review. *Journal of Sex Research*, *49*(2-3), 184-211. doi: 10.1080/00224499.2012.658586
- Yerke, A. F. & Mitchell, V. (2011). Am I man enough yet? A comparison of the body transition, self-labeling, and sexual orientation of two cohorts of female-to-male transsexuals. *International Journal of Transgenderism*, *13*(2), 64-76. doi: 10.1080/15532739.2011.622125.
- Zamboni, B. D., Robinson, B. E., & Bockting, W. O. (2006). Body image and sexual functioning among bisexual women. *The Haworth Press, Inc.* doi: 10.1300/J159v06n04\_02.

## Curriculum Vitae

TRISTAN K. MARTIN

### Education

**Ph. D. Marriage & Family Therapy**

Syracuse University- Expected 2020  
Advisor: Deb Coolhart, Ph.D., LMFT

**Master of Family Therapy**

Mercer University School of Medicine- 5/16  
Advisor: Andrea Meyer, Ph.D., LMFT

**B.A. Psychology, Cum Laude**

Huntingdon College- 5/14  
Advisor: Kristine Copping, Ph.D.

### Professional Affiliations

**Limited Permit Marriage and Family Therapist** (Sept. 2018 # P10033)

**World Professional Association for Transgender Health (WPATH)**

Student Member

**American Association of Marriage and Family Therapy (AAMFT)**

Student Member

**United States Air Force Reserve**

Honorable Discharge- 2014

\***Certifications:** Professional Rescuer/CPR/AED

### Professional & Clinical Experience

**CNY Marriage & Family Therapy Place**

Limited Permit Marriage & Family Therapist  
Syracuse, NY

8/18-present

**Therapist**

Rainbow Access Initiative  
Albany, NY

4/18-8/18

**SUNY Upstate Medical University Transgender Team Therapist**

Syracuse, NY

1/18-4/18



**Professional & Clinical Experience (continued)**

<b>Licensing Material Developer</b> Association for Advanced Training in the Behavior Sciences (AATBS)	9/17-2/18
<b>Syracuse University</b> Marriage & Family Therapy Program Doctoral Candidate & Research Assistant	8/16-present
<b>Syracuse University Couple &amp; Family Therapy Center</b> Doctoral Student Therapist Transgender Treatment Team Clinical Case Consultation (towards Approved Supervisor status)	8/16-8/18
<b>Navicent Health Medical Center</b> Inpatient Behavior Health– Macon, GA Graduate Student MFT Intern	8/15-8/16
<b>Mercer University Counseling &amp; Psychological Services</b> Graduate Student MFT Intern	8/15-6/16
<b>Mercer Family Therapy Center</b> Graduate Student MFT Intern	8/15-8/16
<b>United States Air Force</b> Reservist	1/12-5/14

**Teaching Experience**

<b>Syracuse University</b> Instructor (co-taught with Deb Coolhart, Ph.D., LMFT) (G) MFT 688 Relationship Therapy with LGBTQ Clients	Winterlude 2018
Guest Lecturer: (G) MFT 625 MFT Theories for Non- MFT's <i>Experiential Family Therapy</i>	Spring 2019
(G) MFT 682 Marriage and Family Therapy Theory and Techniques <i>EFT &amp; ABFT</i>	Spring 2018
(G) MFT 567 Sexual Issues for the Helping Professional <i>Sexual Compulsivity</i>	Summer 2017 & 2018
(G) MFT 671 Introduction to Family Systems <i>Bowen Family Therapy</i>	Fall 2017
(G) MFT 688 Relationship Therapy with LGBTQ Clients <i>LGBTQ &amp; Spirituality</i>	Winterlude 2017
(G) MFT 750 - Introduction to Marriage & Family Therapy Practicum <i>Citi Training</i>	Fall 2016

## **Teaching Experience (continued)**

### **United States Air Force Reserve Officer Training Corps**

Instructor

(UG) Field Training Preparation

(UG) Leadership Laboratory

Spring 2013

Fall 2014

## **Publications**

Coolhart, D. & **Martin, T.K.** (in press). Gender affirmative therapy with trans and gender expansive (TGE) youth and families: Listening to youth and thoughtfully following their lead. In *Handbook of LGBT-affirmative couple and family therapy*. Routledge.

**Martin, T.K.** (in press). Fitness saved me. In *Trans bodies trans selves: A resource for the transgender community*. Oxford University Press.

**Martin, T.K.** & Coolhart, D. (2019). "Because your dysphoria gets in the way of you...it affects everything." The mental, physical, and relational aspects of navigating body dysphoria and sex for trans masculine people. *Journal of Sexual and Relationship Therapy*. doi: 10.1080/14681994.2019.1696459.

**Martin, T. K.** & Martin, R. H. (2019). Psychological and physical problems of being Overweight or Obese in Law Enforcement and the Impact on the Job Performance and Personal Lives: Control, Perception, and Assistance. *EC Psychology and Psychiatry*, 8, 158-164.

Shipman, D. & **Martin, T. K.** (2019). Clinical and supervisory considerations for transgender therapists: Implications for working with clients. *Journal of Marital and Family Therapy*, 1-14. doi:10.1111/jmft.12300.

**Martin, T. K.** (2017). Intersections: Gender and mental health. *FTM Magazine*.

**Martin, T. K.** & Martin, R. H. (2017). Police suicide and PTSD: Connection, prevention, and trends. *Law Enforcement Executive Forum*, 17(2), 27-41.

## **Research in Progress**

Coppola, J & **Martin, T. K.** Attachment and relationship satisfaction for therapy-seeking transgender individuals: A brief report.

## **Professional Presentations**

Fanelli, J., **Martin, T. K.**, & DeMauro, J. "Sex in the Dark." Sexpert Panel, Syracuse University Health Services, 2017, 2018, 2019.

### **Professional Presentations (continued)**

- Coppola, J. & **T. K. Martin**. “A profile of therapy-seeking transgender clients & implications for therapists.” LGBTQ Research Symposium University of Illinois-Champaign, Champaign, IL, 2018.
- Martin, T.K.** “Weight Training to Masculinize the Body.” Proposal presented at the Philadelphia Trans Wellness Conference, Philadelphia, PA, 2018.
- Coppola, J. & **Martin, T.K.** “A Profile of Therapy-Seeking Transgender Clients and Implications for Therapists” Poster displayed in the Falk Student Research Celebration, Syracuse University, 2018.
- Martin, T.K.** & Shipman, D. “Considerations for Transgender Therapists.” Proposal accepted for the American Family Therapy Academy (AFTA) Conference, Austin, TX, 2018.
- Martin, T. K.**, Coppola, J., & Coolhart, D. “Transgender Inclusive Training Issues & Experiences in MFT Programs.” American Association of Marriage and Family Therapists (AAMFT) Conference Louisville, KY, 2018.
- Gangamma, R., Stanton, S., & **Martin, T.K.** “Experience and Knowledge of Child Sexual Abuse (CSA) & It’s Influence on Adult Intimacy in a Clinic Population.” Brown Bag Research Discussion, Syracuse University, 2017.
- Martin, T.K.**, Coolhart, D., Coppola, J., McEachern, M., & Stanton, S. “Sex Symposium.” Brown Bag Research Discussion, Syracuse University.
- Davis, K. J., **Martin, T. K.**, Holland, J., Ross, D. B., & Meyer, A. S. “Addressing Pediatric Obesity through Integrated Care: Therapeutic Practices of the “Healthy Me” Program. Presentation at Georgia Association of Marriage and Family Therapy Conference, Jekyll Island, GA, 2016.
- Martin, T. K.**, Holland, J., Davis, K. J., & Meyer, A. S. “Behavioral Health: Integrating Marriage and Family Therapists in Pediatric Primary Care.” Presentation at Georgia Association of Marriage and Family Therapy Conference, Jekyll Island, GA, 2016.
- Martin, T.K.** “Graduate School Opportunities” Invited lecture at Huntingdon College. Montgomery, AL, 2015.

### **Professional Honors/Awards**

- |  |      |
|--|------|
| <b>SU Graduate School Summer Dissertation Fellowship</b> | 2019 |
| <b>Mazzoni Center Travel Grant</b><br>Philadelphia, PA   | 2018 |

**Professional Honors/Awards (continued)**

<b>GSO Travel Grant</b> Syracuse University	2018
<b>Hendricks Chapel Travel Grant</b> Syracuse University	2018
<b>L.G. Bailey Psychology Award</b> Huntingdon College	2014
<b>Alpha Beta Kappa National Honor Society</b> Huntingdon College	2014
<b>AFROTC National Society Daughters of Founders and Patriots of America Award</b>	2013
<b>AFROTC Military Order of the Purple Heart National Leadership Award</b>	2013
<b>NCAA Div. III National Tournament 2<sup>nd</sup> Round Participant</b> Huntingdon College, Basketball	2013
<b>Who's Who among Colleges and Universities</b> Huntingdon College	2013
<b>AFROTC Veterans of Foreign Wars Award</b>	2011