“THAT’S THE SICK TRANS PERSON”: NEGOTIATIONS, HEALTHCARE, AND THE TENSION OF DEMEDICALIZATION

A thesis submitted for the degree of Doctor of Philosophy

by

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Abstract

This dissertation addresses two key issues: the barriers between trans people and quality healthcare and the ways in which trans people overcome those barriers. Based on research that included interviews with trans people in the U.K. and autoethnography, this thesis articulates a fundamental tension between a) making an argument for demedicalization based on the harms of the current medicalized model, and b) the fact that some trans people are reliant on medical technologies. Within the course of examining this tension the dissertation contributes to the disciplines of trans studies by: highlighting barriers to quality healthcare so that they may begin to be removed; uplifting trans voices and experiences as rich sources of knowledge; better understanding gender and how it operates socially, and imagining new possibilities for trans models of health and healthcare. Additionally, this work outlines and demonstrates a model for a trans methodology.

In laying the groundwork for the dissertation's argument I come to an understanding of sex and gender as two related but equally socially constructed and ultimately self-determined characteristics. In addressing the first issue I identify how transness has been medicalized along with the benefits of demedicalization and look at how bureaucracy, time, and space factor into trans health. In addressing the second issue, I focus on the specific knowledges trans people accumulate in order to navigate accessing healthcare (what I call TransLiteracy) and the social and decentralized model of pedagogy used to teach and learn these knowledges. The dissertation concludes with an articulation of an imagined healthcare system which presumes a trans subject and a way of accessing medical technologies without medicalizing transness. Thus new perspectives on transness, medicalization, and research methodologies are offered as additions to the growing body of work on trans health in the U.K. and globally.

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Introduction

This dissertation analyzes trans health in the U.K. through two key questions. Firstly, what barriers are there between trans people and the ability to access quality healthcare? Secondly, when they are able to at all, how do trans people overcome those barriers? Understanding these barriers suggests demedicalization as a solution which brings up a central tension of this thesis, one between demedicalizing transness and ensuring continued access to medical technologies for trans people who require them. I have found that there are significant and unique obstacles that delay or prevent trans people from accessing both transition and non-transition related healthcare. However I have also found that in many cases trans people are able to overcome or at least push back against these barriers in creative and effective ways. Additionally, I outline a trans methodology which has developed throughout the course of this project. Overall this dissertation paints a picture of a healthcare system struggling to meet the needs of a population and illuminates what we can learn from that population's response to that struggle.

Disciplinary Home

Throughout this work I draw inspiration and knowledge from multiple disciplines, but ultimately the best home for this dissertation is trans studies. While fairly new, the field of trans studies has a growing body of work and is interdisciplinary and deeply socially engaged in nature. In (De)Subjugated Knowledges: An Introduction to Transgender Studies, Susan Stryker describes the field thusly:

> "Most broadly conceived, the field of transgender is concerned with anything that disrupts, denaturalizes, rearticulates, and makes visible the normative linkages we generally assume to exist between the biological specificity of the sexually differentiated human body, the social roles and statuses that a particular form of body is expected to occupy, the subjectively experienced relationship between a gendered sense of self and social expectations of gender-role performance, and the cultural mechanisms that work to sustain or thwart specific configurations of gendered personhood." (Stryker, 2006, pg. 3)

This description not only fits this dissertation but is a road map for the kind of questions I hope to continue to explore throughout my career.

My previous academic background is in anthropology, specifically medical anthropology, and I draw on that background heavily in the development of this thesis particularly in terms of understanding medical systems as part of culture. With this project however I leaned more toward sociological theories to understand gender as a social position and the ways that transphobia and cisnormativity operate in society. The subtle mix of medical anthropology and sociology are prevalent throughout but I also draw on feminist studies, queer studies, psychology, philosophy, biology, and medicine. Using this kind of interdisciplinary approach to better understand trans experiences along with the methodology that I will outline later situates this thesis within the now well established discipline of trans studies.

Importance

The importance of this research on a more basic level is to help illuminate barriers that trans people face when accessing healthcare. Identifying these barriers is the first step to having them removed and the often creative solutions trans people find to get around or at least push back against these barriers may inspire broader policy solutions. In a much larger sense this work says something about the human condition. All people have a relationship to gender, it is simply the case that with trans people that relationship is brought to the fore, making it an excellent vessel for discussing how gender operates. This dissertation oscillates between the small, specific, and personal details that make up lived experiences, and discussions of a fundamentally changing paradigm of what it means to be human through a (re)understanding of gender.

Personal Importance

In addition to the reasons stated above, this topic is of personal importance to me as a trans person living in the U.K. My theoretical groundwork was laid as an undergraduate within critical medical anthropology where I learned to seek the “real world” application of my research and became intent on focusing all my academic work on pursuits that will be of service to the communities[1] I work with. Having completed

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[1] I am following Ruth Pearce (2018) here in using the plural “communities” to avoid misrepresenting trans people as a monolith.

research projects for my first two degrees that I felt were of service (but to communities to which I do not belong) coupled with my increasing involvement in trans communities following a growing understanding of my own relationship with gender during my master's degree year, I embarked on this project. I felt almost an obligation to use this opportunity, perhaps selfishly, to develop knowledge that will hopefully help improve access to and quality of healthcare for myself and other "gender outlaws[2]" like me.

Ethics

This research was approved by the Research Ethics Committee at Brunel University London. It was initially approved on 27/07/16 with the recruitment method of putting up flyers and making announcements at trans meetings and events followed by snowball sampling. I later submitted an amendment to add posting to trans Facebook groups to my recruitment strategy, which was approved on 09/06/17.

Informed Consent

Within the process of arranging the interviews I reminded the participants that I would be changing their names and making their contributions anonymous. Before beginning the interviews, each participant was given an information sheet to read and keep for future reference (Appendix A). After reading the information sheet and agreeing to participate each participant signed a consent form (Appendix B). After each interview, I took the signed consent form to the office of my supervisor where they are kept in a locked drawer. All participants have my contact information and have been informed that they can withdraw their consent to participate at any time.

Anonymity

In order to keep the participants anonymous I have chosen pseudonyms for them and generalized or left out potentially identifying details. I started the anonymizing process at the stage of transcribing the interview so that even the raw data would not be traceable back to any individual. As I was transcribing, I changed the participant's name and changed or left out other details including the name of partners, places of work or

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[2] To borrow Kate Bornstein's term.

study, and profession. I was generous with the information I changed or left out because although there may be a large number of people in, say, a given job, there may not be many trans people in that job so the intersection of those two pieces of information combined with the location of this research could potentially identify someone.

I chose pseudonyms by letter of the alphabet, so the first participant has an A name, the second a B name, and so on. This helped in note taking and analysis. Beyond the first letter however I did put thought into the names I chose. I tried to choose names with a similar gendered connotation to the name the participant went by. Adam, for example, has a typically masculine name so I chose a typically masculine pseudonym for him. Carey has a traditionally gender neutral name so I chose a similarly gender neutral name for them. I did this not because there is anything inherently gendered about names. Indeed, names are gendered differently cross-culturally, for example I remember being confused when a British friend told me they were changing their name to “Hillary” to make it more gender neutral because where I grew up (in the Northeastern U.S.) that name has a strictly feminine connotation. I certainly am not invested in naturalizing the gendered connotations of names, however, I cannot ignore the fact that names do have such connotations and that the participants chose their names with the knowledge of how those names are read in the social spheres they occupy. The participant Flora is transmasculine and has changed their name, but they kept a typically feminine first name (but have a typically masculine middle name). To select a traditionally gender neutral or masculine name for them because of their gender would erase that very conscious and interesting choice that they made. Additionally, all of the participants also had fairly common English names so the chosen names reflect that as well.

In order to maintain the anonymity of the doctors and other medical professionals that the interviewees discussed, I omitted any direct quotes from those sections. Upon review I decided that even if I changed the names of the medical professionals it was still too easy to identify them as most Gender Identity Clinics (GICs) have a fairly small staff without much overlap in roles and there are not very many clinicians offering private gender services. Therefore any time an interviewee discussed a specific medical professional in a way I thought was relevant enough to include in this thesis, I summarized what was relayed to me rather than using any direct quotes, along with generalizing jobs, and/or omitting details, in order to maintain their anonymity.

Participants

Throughout the dissertation I will be referring to all of the participants by the first name I chose for them but I would like to give a more detailed introduction to them all here. I am recounting their race, gender, and pronouns verbatim in the ways they were explained to me in the interviews.

- Adam is a 34[3] year old white man who uses he/him/his pronouns.
- Ben is a 24 year old Arab transmasculine person who uses he pronouns.
- Carey is a 21 year old white British non-binary/agender person who uses they/them pronouns.
- Dan is a 34 year old mixed race man who uses he pronouns.
- Emily is a 69 year old white British trans female who uses she pronouns.
- Flora is a 20 year old white British person who described their gender as "non-binary, gender fluid, transmasculine but I also feel like I'm really femme…just yeah an affinity with all of those" and uses they/them pronouns.
- George is a 28 year old white Welsh male who uses him pronouns.
- Holly is a 40 year old mixed (white and middle-eastern) non-binary person who uses she pronouns and explained "I don't feel the need to identify specifically in the non-binary umbrella, I would feel more on the female side of the spectrum but not necessarily one".
- Ingrid is a 60 year old white Welsh female who uses she/her pronouns.
- I am a 25 year old white American who uses they/them pronouns.

Overview of Chapters

Methodology

In the first chapter I describe the methodology that has developed throughout this dissertation. I begin by laying out my formulation of an ethics of a specifically trans

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[3] All ages given here are the age they were at the time I interviewed them. For myself I have given my age at the time of submitting this dissertation.

methodology. Following trans scholars Paul B. Preciado, Lucas Crawford, and others, and inspired by other minority studies, I describe the highly community focused approach to research, analysis, and dissemination that I took while completing this work, as well as ways that I can move toward an even more community centered approach with future research. With this in mind I discuss my process for recruitment of participants, interviews, transcription, data analysis, and writing. I explain how I use autoethnography in this work, following many trans scholars including Dean Spade and J.R. Latham.

Background and History

In the second chapter I lay the groundwork for the rest of my discussion with the necessary background information and a small sampling of the rich history that is essential to understanding and situating this dissertation. I begin by introducing key terminology and defining how I will be using these terms, including a brief history of the varied words used to describe trans people (Adams, 2015), and an explanation of why I use “trans”. This is not an exhaustive list so other less fundamental words will be defined throughout in the footnotes and there are glossaries at the end for all of the acronyms and medical terminology. I then go into additional background information, explaining intersex variations and their role in this dissertation, discussing violence against trans people, and describing the understanding of the scope of health that I am approaching this work with. I then provide some historical context, describing Dr. Magnus Hirschfeld’s foundational work from in the late 1800s and early 1900s and highlighting some of the first trans people in the U.K. who are known to have accessed transition related healthcare. Next I give a brief history and description of the relevant current policies, practices, and remits of the NHS, provide some clinician perspectives, and address the role of private healthcare. I finish by detailing The World Professional Association for Transgender Health (WPATH) ‘Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People’ which is internationally referenced as a model of how to provide care for trans people. This background and history merely scratches the surface but what I have provided here will serve as a primer to understand the analysis of trans healthcare in the U.K. that will follow.

Understanding Sex and Gender

In this chapter I argue for moving past an understanding of sex and gender as completely separate and unrelated phenomena and toward one that comes to terms with the ways in which they are intertwined. To do this I look at the work of Emily Martin and Anne Fausto-Sterling to lay out how our understanding of “biological sex” is influenced by cultural ideas of gender. This leads to the very problematic idea that there are “male” and “female” bodies and that the only possible explanation for trans existence is that trans people were “born in the wrong body” (Bettcher, 2014). I unpack the problems associated with this model, and critically address some alternative models including the “beyond the binary” model. I then explore how sex and gender are actually attributed (Blackless et al., 2000; Kessler and McKenna, 1978/2006; Roughgarden, 2004/2013). I try, and fail, to concretely define male-bodiedness and female-bodiedness and so instead explore how sexes and genders are assigned, both in everyday life and in healthcare settings. I then challenge the need for attributing sex and gender to others in the first place and propose a model of sex and gender where these concepts are equally socially constructed and can only be determined and articulated by the individual.

Medicalization

In the fourth chapter I argue for the demedicalization of transness as a key way to remove existing barriers to health. The current edition of the World Health Organization’s (WHO) International Classification of Diseases (ICD)[4] classifies several “gender identity disorders”: transsexualism, dual-role transvestism, gender identity disorder of childhood, other gender identity disorders, and gender identity disorder, unspecified. The NHS simplifies all of these guidelines into a diagnosis of “gender dysphoria” which can also be referred to as “gender identity disorder”. This diagnosis and the corresponding “treatments” of psychotherapy, hormone replacement therapy, and assorted surgeries represent the contemporary medicalized model of transness in

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[4] I will be referring to the ICD-10 Version (2016) which was the most up to date version at the time of writing. The ICD-11 was not adopted by the World Health Assembly until May 25th, 2019, several months after the submission of this thesis and it is still in the process of being implemented (WHO, 2019).

the U.K. To best understand how medicalization operates and therefore how to counter it I use the extensive work of Peter Conrad. First I outline their classificatory system which distinguishes between conceptual, institutional, and interactional medicalization, all of which can be understood as functioning toward the medicalization of transness. Conrad also differentiates between deviant and natural life course medicalized behavior. However, in this instance, I depart from Conrad and propose that transness crosses the boundary between ‘deviant’ and ‘natural’ and exists as both. I then follow Conrad in positing potential causes of medicalization, including secularization and the nature of the medical profession itself, but finally argue that both are too simplistic in and of themselves to explain this complex process. What I do argue is that medical social control (Foucault, 1973[5]), like other forms of social control, is exerted over trans people and serves to limit what healthcare they can access and how they can access it. In the second portion of the chapter, I look at possibilities for limiting or eliminating that medical social control, in other words I outline a proposal for demedicalization. Here I use the work of George Canguihem and compare some of the problems with the demedicalization of homosexuality with the proposed demedicalization of transness. In spite of these challenges, I propose that a non-pathologizing model for transness is necessary and urgent[6].

Bureaucracy, Time, and Space

In this fifth chapter I expand upon the discussion of medical social control outlined in the previous chapter by analyzing some the mechanisms that are used to exert power over trans people. I start by looking at healthcare in the U.K. as a bureaucracy which illuminates the structure of gatekeeping and barriers that are placed between trans people and accessing the healthcare they need. The elements of these bureaucracies that the participants helped illuminate, including cancelled appointments,

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[5] *The Birth of the Clinic: An Archaeology of Medical Perception* was first published in French in 1963 (as *Naissance de la clinique: une archéologie du regard médical*) but the English translation was published in 1973.

[6] The specifics of how to implement this power shift could be the topic of another inquiry altogether and are beyond the scope of this dissertation. However it is worth noting that the demedicalization I will advocate for in Chapter 4 will not come about from one single event but will rather require an evolution of medicine over (potentially quite a long) time. This dissertation is merely one small part of that process.

"ticking boxes", jumping through hoops, shifting responsibility, the structure of forms, and social networks (Varela 2001), are all sites in which trans people come up against barriers they must navigate to access their healthcare. As an example I compare the referral forms for Northampton and Charing Cross GICs[7] to those for Whittington Health Musculoskeletal Physiotherapy[8], Camden and Islington Mental Health Services[9], and NHS Wales "female breast reduction"[10]. I also look at time as a key factor in these power structures which particularly manifests as waiting. I use Brown et al.'s work on waiting for a liver transplant to unpack how waiting operates in a healthcare context and I consider some of the ways people deal with waiting including an understanding of what makes waiting easier (Maister, 2005) and a more positive perspective on taking time (Israeli-Nevo, 2017). Finally I look at the physical spaces in which trans people create and enact their gender, particularly waiting rooms and bathrooms, with the help of Lucas Crawford's work on transgender architecture. These spaces, time, and state and medical bureaucracies are simultaneously tools and loci of power which can keep trans people from maintaining or achieving health.

Pedagogy and TransLiteracy

In the final chapter I look at how trans communities use an alternative form of pedagogy, one that is social and decentralized, to exchange unique and targeted knowledges, what I call TransLiteracy. I specifically highlight the ways in which trans people learn to strategically deploy personal narrative (Spade, 2000/2006; Latham 2016), but I recognize a wide range of knowledges that are exchanged in this way. This includes everything from how to get referred to a GIC to what shirts would be flattering: basically anything and everything a trans person may need to know in order to navigate

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[7] I chose these specific GIC referral forms because they are the only GICs used by participants in this research.

[8] I selected Whittington Health Musculoskeletal Physiotherapy as an example of a self-referral form because it is a service I have used myself. This allows me to speak about my first-hand experiences with a self-referral model.

[9] Camden and Islington Mental Health Services was chosen as an example mental health services referral because, again, it is a service that one of the participants has previously accessed.

[10] The only publicly available breast reduction referral form that I could find was the NHS Wales form. The comparison between "female breast reduction" and top surgery is a valuable one so I included this form even though it is not a service that any of the participants have accessed.

the world. These knowledges are dispersed in different ways but I focus on social media as a key pedagogical tool. I use the early work of Mark Poster to understand the unique features of the internet that lead to it being such an important communication and narratological medium. Specifically, I investigate how trans people use YouTube (Raun, 2016), Facebook (Duguay, 2016), Instagram, and Twitter, and I show how this model is incredibly effective. Being decentralized decreases gatekeeping by experts[11]. Every participant in this information exchange can, at one point or another, act as both the teacher and the student, adding to or learning from the lived experience of these communities. Being social contextualizes and personalizes the information as well as providing a diverse range of voices, ensuring the person trying to learn has the best opportunity to get accurate and helpful answers to their questions[12]. The social aspect of pedagogy along with specific trans knowledges such as understanding the trans dialect and identifying allies and fellow trans people further help to build community. In this way pedagogy and TransLiteracy help trans people overcome barriers to their health through becoming better able to access transition and non-transition related healthcare, getting advice that can help alleviate distress, and building community which bolster good mental health.

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[11] I am referring here to the ability for people to easily share information with very few barriers to publication. This in contrast to, for example, information that is published in an academic journal or a newspaper. There is of course gatekeeping that happens on these sites with algorithms determining what shows up in feeds and search results, however that is distinct from the gatekeeping of what gets published in the first place that happens with other sources of knowledge. Additionally, many of the examples I will discuss in Chapter 6 concern content that is found through very specific searches or is published within smaller online communities, such as secret Facebook groups, which bypasses some of these issues.

[12] Although of course they may not always be successful in accessing that accurate information.

Chapter 1: Methodology

In this first chapter I explain the methodology, which I argue is itself a key finding of this research. I begin with outlining my ethical framework for a specifically trans methodology. This framework centers around four elements: a) that the research is done entirely within the communities, b) that if interviews are used they center the voices of trans people in their own words, c) that the research is written up in a trans style (which I describe in more detail below), and d) that the research is disseminated back into the communities in an accessible way. This is a methodology that I hope to continue developing and improving throughout my career. Following this section I go into more detail about the methods of recruitment, interviewing, transcription, analysis—using the work of Bryman, Aronson, Guest et al., and Braun et al.—, and writing I have used in this project. I conclude the chapter by theorizing the role of autoethnography in trans studies generally and in this dissertation specifically, using the work of Ellis, Boylorn and Orbe, Chang, Adams, Gergen and Gergen, and Jones to craft what I call an autoethnography of always.

Towards a Trans Methodology

One of the key aims of this dissertation is to identify what ethics and practices might make up a specifically trans research methodology. I argue here that the first feature of such a methodology is that the research is done entirely within the communities, which is to say that it is done by trans people[13]. It is my firm belief that the only ethical body of scholarship regarding a marginalized group can be constructed by and within that group. It is possible that there are exceptions to this rule but only by cis scholars who collaborate closely and fully with trans colleagues and have a deep

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[13] I define "trans" as I am using it here and address some of the limitations of this term in Chapter 2, but in short, "trans" is simply the umbrella term I have chosen. Another scholar may identify themselves and/or their participants with a different umbrella term (such as J.R. Latham who uses the term "transexual") but could still fall under this methodology if discussing the same communities.

reflexive understanding of their own cisgender privilege[14]. While not an exact corollary I am inspired by Black, indigenous, and other scholars of color researching and creating scholarship on race. In *The Imperial Scholar: Reflections on a Review of Civil Rights Literature* legal scholar and one of the founders of critical race theory Richard Delgado states:

> "While no one could object if sensitive white scholars contribute occasional articles and useful proposals (after all, there are many more of the mainstream scholars), must these scholars make a career of it? The time has come for white liberal authors who write in the field of civil rights to redirect their efforts and to encourage their colleagues to do so as well. There are many other important subjects that could and should engage their formidable talents. As those scholars stand aside, nature will take its course; I am reasonably certain that the gap will quickly filled by talented and innovative minority writers and commentators. The dominant scholars should affirmatively encourage their minority colleagues to move in this direction, as well as simply to make the change possible". (1984, pg. 577)

Here Delgado is calling not for white scholars to completely abandon the discipline, but rather to take responsibility for ushering in the new era of scholarship that centers scholars of color. Trans studies has already achieved a robust catalogue of work created by trans people, some of which is highlighted throughout this dissertation. This work is theoretically rich and has moved the discipline into new and interesting places. It is in this tradition that the trans methodology that I propose would continue.

The second feature of a trans methodology is that when interviews are conducted the interview style must be interrogated. It is absolutely essential to center trans voices in their own words, thus interviews are arguably a superior medium of data gathering. Specifically, I argue that open ended interviews that are unstructured or only loosely structured are best because they minimize the limiting effect that an interviewer's specific questions can have on what the interviewee says. In combination with the first tenet, the interview experience itself will be smoother because the

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[14] "Privilege" here refers to social advantages experienced by groups of people based on their having certain characteristic(s). Palczewski et. al. define privileges as "unearned freedoms or opportunities. Often, privileges are unconscious and unmarked. They are made to appear natural and normal through cultural hegemony, which makes them easy to deny and more resistant to change." (2017, pg. 31). See also McIntosh, 1988 and 2015.

participant will not need to educate the interviewer on “trans 101” and the conversation and subsequent analysis will not be mediated through the cis gaze[15]. In addition to the benefits for the research, this interview style might be useful to the participants. The opportunity to speak for and about oneself is essential to creating one’s own identity (see Chapter 5) and participating in this type of interview potentially allows interviewees the opportunity to construct personal narratives in whatever way is meaningful to them.

This methodology’s third key feature is the style of writing. I use a gender neutral pronoun throughout (I have chosen the singular “they”, a choice I go into detail about in Chapter 2) unless the person has told me that their pronouns are otherwise. I attempt to be cognizant of and to challenge biological essentialism and naturalization of “gendered” traits at every turn. The writing style also includes weaving personal narrative in with theory (a la Paul B. Preciado’s *Testo Junkie*, 2013[16]). Most importantly, however, is how I write about the participants and their experiences. I do not approach them as though they themselves or their experiences are fixed. Rather, I see the interview as a snapshot of a moment in time that does not necessarily tell me anything about how these people have been or will be. I recognize the value in what they are able to relay without presuming that their experiences, opinions, identity, or anything else will remain stable. If I went back to the same participants in a few years time it is very possible that some would identify their gender differently or that their perspective of the healthcare system would have become more positive or more negative. Indeed, the one participant who I was able to interview twice, Adam, consistently reported his gender simply as a “man”. However, in the first interview he additionally described his gender experience as that of a “transgender man” but said that he was somewhat uncomfortable with that term. In our second interview, about seven months later, Adam had found the term “man with a trans history” which he felt suited him much better. Allowing for fluidity does not weaken my data set but in fact strengthens it by

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[15] This is a play on feminist film scholar Laura Mulvey’s concept of the “male gaze” in which they argue that women are always-already viewed and presented (in Mulvey’s focus in film) from the perspective and for the enjoyment of heterosexual men as the dominant social group (1975). I am translating this famous term here to apply to cis people as the dominant social group (a la Cava 2016) and expanding it beyond film to include representation of the marginalized social group (in this case trans people) in other mediums, specifically research outputs.

[16] *Testo Junkie* was originally published in Spanish in 2008 but I am referencing the 2013 English publication.

acknowledging its limits and recognizing that identity and individuals are always in states of flux.

The final and perhaps most ethically important feature of a trans methodology is that the research products go back into the communities. A PhD as a written product is inaccessible to the vast majority of people in trans communities, so this requires that the information be brought into trans spaces and actively made accessible through texts like presentations and brochures[17]. The next evolution of this ethic would be research that never truly leaves trans communities. Poet and trans studies scholar Lucas Crawford highlights the importance of this in their 2015 book *Transgender Architectonics: The Shape of Change in Modernist Space*: “writing a theory of spatiality that presumes a transgender visitor to the space or transgender reader of this book is its own attempt to make new reading practices” (pg. 163). So perhaps in future, rather than doing insider community research, bringing it back to the academy to analyze and disseminate, and then bringing accessible results to communities, every stage of the research would take place within and in conversation with trans communities. This would fundamentally challenge the role of the university in this type of research or perhaps reshape the boundaries of the university itself.

Dynamic Methodologies

This methodology was not one that was decided on in advance of this project and then put into practice, but rather came about during and as a result of this project. Therefore several adaptations were made in the process of writing this dissertation, such as shifting from using trans* as an umbrella term, which was still widely deployed when I began this project in 2015 but had mostly fallen out of use by 2018. Another example is that the interviews became increasingly less structured as it became apparent that the interviewees knew the stories that were relevant to them and did not need much guidance beyond a general conversation topic. It is in this spirit that I acknowledge that the minutiae of the trans methodology that I have outlined may change, in fact that it must change, in the future guided by the communities being researched.

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[17] See the conclusion for more plans for research dissemination.

Other Minority Studies

This trans methodology has been heavily influenced by general trends across minority studies, specifically those within critical race theory (CRT)/critical race studies (CRS), disability studies, and fat studies[18]. As I will outline below, each of these bodies of literature share several traits with this trans methodology. These include conducting research completely within communities, interdisciplinarity[19], and privileging the first-hand accounts of people within those communities. Each of them provides a useful framework for researching specific marginalized minority groups.

Critical Race Theory

Just as this trans methodology advocates an applied approach, CRT includes an important activist element. It is collaborative and community based, or as Delgado and Stefancic describe in *Critical Race Theory: An Introduction*, it is “a collection of activists and scholars engaged in studying and transforming the relationship among race, racism, and power” (2017, pg. 3). This distinguishes CRT from civil rights discourse in that it is focused on questioning and reimagining entire systems rather than on making incremental progress toward achieving equal rights. The basic tenets of CRT recognize that “racism is ordinary, not aberrational” (Delgado and Stefancic, 2017, pg. 8), that white supremacy benefits white people and serves important social, cultural and symbolic purposes for them, and that race is a social construct. These tenets are rooted in valuing and validating the lived experiences of people of color, which is similar to the aims of this trans methodology with regard to trans people. CRT also recognizes and values intersectionality and supports the “voice-of-color thesis”.

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[18] While Feminist Standpoint Theory has not been a specific inspirationhere, the methodology that I propose does share similarities with it. Both methodologies work to recast marginalized groups as active subjects who take part in knowledge production, rather than as merely objects available to the research scrutiny of outside “experts” (Harding, 2004).

[19] While this is not one of the main features of this methodology, it is interdisciplinary both in the sense that it can be applied throughout different disciplines as well as that it is advantageous to draw knowledge from different disciplines as I discussed in the Introduction.

> “[T]he voice-of-color thesis holds that because of their different histories and experiences with oppression, black, Indian, Asian, and Latino/a writers and thinkers may be able to communicate to their white counterparts matters that whites are unlikely to know. Minority status, in other words, brings with it a presumed competence to speak about race and racism” (Delgado and Stefancic, 2017, pg. 11).

I would be remiss to simply replace the voice-of-color thesis with something like a “voice-of-trans” thesis because being a person of color and being trans are in no way analogous, as I explain below. Indeed the voice-of-color thesis could be added to this methodology by a trans person of color in order to study their own communities. However, the idea of the voice-of-color thesis has strongly inspired the first (the research is done entirely within the communities) and second (if interviews are used they center the voices of trans people in their own words) elements of this trans methodology.

In addition to these similarities, CRT and trans studies generally share an interdisciplinary approach. While CRT has its disciplinary roots in law schools and legal studies, over the last few decades it has also become important to social science and humanities disciplines. As Angela Harris explains in the forward to *Critical Race Theory: An Introduction:*

> “[c]ritical race theory has exploded from a narrow sub-specialty of jurisprudence chiefly of interest to academic lawyers into a literature read in departments of education, cultural studies, English, sociology, comparative literature, political science, history, and anthropology around the country[20]” (2017, pg. xvi).

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[20] Harris is referring here to the spread of CRT in the U.S. However, it has also gained international popularity, including in the U.K. where this research is based (Chakrabarty et al., 2012).

This ability to not only speak across disciplines but to use the strengths and insights of diverse disciplines to one's advantage as a researcher is crucial to the trans methodology that I outline in this chapter.

Disability Studies

This trans methodology highlights the importance of researchers who have lived experience of the area they are researching and showcases other voices from within the communities being researched. Both of these methodological strategies are also applicable to disability studies. James Charlton describes their approach to writing their book *Nothing About Us Without Us: Disability Oppression and Empowerment* as one of foregrounding the first hand experience of disability, both their own and that of others:

> “This book is founded principally on the everyday life of people with disabilities. It derives first and foremost from my own particular experiences as a person with a disability and as an activist in the disability rights movement in the United States. Second, it comes out of others' experiences described in conversations, discussions, and interviews or excerpted from the existing literature”. (2000, pg. 5)

Here Charlton describes lived experience as foundational, whether it be accessed from the personal experience of the author, from interviews and conversations with other community members, from existing literature, or in their case (as in mine), all of the above. They also specifically mention their activism. It is not only notable that they are coming to this writing as a person with a disability, but also that they are bringing their perspective and experience as a disability rights activist to research, methodology, and theorization. Finally, disability studies and this trans methodology are concerned with challenging what constitutes a “normal” embodiment. As Lennard J. Davis states in the introduction to The Disability Studies Reader, "the 'problem' of disability does not lie with the person with disabilities but rather in the way that normalcy is constructed" (2016, pg. 1). This eye toward unpacking and dismantling oppressive ideas of normalcy is an important factor of this methodology.

Fat Studies

Following the fields of study mentioned above, another source of inspiration for this trans methodology comes from the field of fat studies. As Rothblum and Solovay explain in their introduction to *The Fat Studies Reader:*

> "[I]n the tradition of critical race studies, queer studies, and women's studies, fat studies is an interdisciplinary field of scholarship marked by an aggressive, consistent, rigorous critique of the negative assumptions, stereotypes, and stigma placed on fat and the fat body" (2009, pg. 2).

Fat studies represents yet another meeting point between academia and activism, the nexus of which is a building block of this trans methodology. In their forward to *The Fat Studies Reader*, author and fat activist Marilyn Wann describes fat studies as "a radical field, in the sense that it goes to the root of weight-related belief systems" (2009, pg. ix). This is precisely how I view trans studies and this trans methodology. It is a radical endeavor, to borrow Wann's phrasing, to go to the root of gender-related belief systems and to disrupt prevailing societal understandings by highlighting the lived experiences of a marginalized minority group.

Additionally, both this trans methodology and the fat studies approaches described here challenge the medicalization of human diversity, particularly diversity of the human body. As Wann describes, "medicalizing diversity inspires a misplaced search for a 'cure' for naturally occurring difference" (2009, pg. xiii). I launch a similar critique against the medicalization of transness in Chapter 4, where I argue for the demedicalization of transness while looking at how to retain access to necessary medical technologies. Fat studies approaches also question the usefulness of "objectivity". Wann argues that because we all live in a systemically fatphobic society, no researcher could possibly be completely objective in their analysis of fat people and fat bodies, regardless of their own position within that system. Furthermore, they state that "claims of neutrality or objectivity in fat studies risk making analyses less credible, not more so" (2009, pg. xviii). I apply this statement equally to trans studies, because, similarly, everyone has an experience with and relationship to gender which makes complete objectivity an impossibility. This is part of what led to the high value that I place on the roles of insider researchers, and to my decision to include autoethnography in the research.

Differentiating a Trans Methodology

Despite the inspiration and areas of overlap, this trans methodology remains distinct from any of the approaches discussed above. The key differentiating factor is the group that is being foregrounded. Highlighting trans identity as the subject of inquiry differentiates this approach, making it distinct from the approaches listed above as well as from other queer studies approaches which privilege sexual orientation. This is because there are important differences in the experiences of different minority and marginalized groups which must, in turn, necessitate different research approaches[21]. For example, despite many ethical and methodological similarities, CRS and critical disability studies cannot be understood as perfectly analogous because of the different experiences of people of color and disabled people and the different ways in which racism and ableism operate. Additionally, some people fall into both minority groups and have unique experiences and challenges. In this example, those unique experiences necessitated the development of a new approach, dis/ability critical race studies (or DisCrit), to analyze that particular intersection (Annamma et al., 2012). Similarly, there could be an endless number of approaches developed which modify this trans methodology in order to research and evaluate the intersections of transness and any number of other marginalized identities, but that is beyond the scope of this work. Because this is a methodology that foregrounds trans people and transness as the singular subjects of research, most of the elements of this methodology are trans specific. This necessitates the highlighting of trans people's voices, using a trans writing style (as described in this chapter), and disseminating the research findings back into

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[21] See Grillo and Wildman's 1991 article *Obscuring the Importance of Race: The Implication of Making Comparisons Between Racism and Sexism (or other -isms)* for more on the pitfalls of specifically comparing all forms of oppression to racism.

trans communities in ways that are specifically tuned to the needs of those communities (for example via presentations in accessible language at trans meet-ups).

Limitations

Any study of a community will struggle with the definition of that community's boundaries, and with this methodology that challenge comes on two fronts. Both the researcher and the participants must be able to understand themselves as belonging to some kind of shared community and/or having a common set of lived experiences. As I have addressed above, selecting an umbrella term for the communities that are being researched (and to which the researcher belongs) is necessary to understand who is included and excluded in this research, although this creates its own problems. Potential participants who do not identify with that umbrella term may not participate in the research and thus the researcher will miss out on those perspectives. I have addressed this by using the most prevalent umbrella term in use at the time of writing ("trans"), explaining in recruitment material that this includes non-binary people, and recognizing that there is no perfect umbrella term that all potential participants will identify with so I will always miss some people. Umbrella terms also change so the research could seem out of date, potentially quite quickly[22] which is why it is important to note that this research is very specifically situated in the U.K. in the mid to late 2010s.

Literature Review

The groundwork for this thesis really began long before I was a PhD student. The preceding years of personal questioning of my own gender identity leading to a greater understanding of my relationship with gender laid the cornerstones. However within the official confines of this PhD, I began by familiarizing myself with the relevant literature, particularly in the fields of gender studies, trans studies, medical social sciences, and medicine. I took a historical approach initially, beginning with some of the oldest material on trans people (Hirschfeld, 1910/2006) and working my way up to the most contemporary writing (Latham, 2016 and later Pearce, 2018). I particularly read works by trans scholars such as Lucas Crawford (2015), Paul B. Preciado (2013), Dean

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[22] I discuss the history of various umbrella terms for trans communities in Chapter 2.

Spade (2000/2006), and Susan Stryker (2006). Then I went back and filled in some gaps by expanding my reading to work that is not specifically about trans people. I read more generally around sex and gender focusing on Judith Butler (1990 and 2006), Suzanne Kessler and Wendy McKenna (1978/2006), and Emily Martin (1991), as well as on medicine and healthcare more broadly with the work of scholars such as Georges Canguilhem (1991), Peter Conrad (1992, 2005, and 2007), and Michel Foucault (1973). Additionally I did not limit myself to traditionally academic books and journal articles, but rather found a lot of rich insight from more "mainstream" work written by trans people including autobiographies such as Janet Mock's *Redefining Realness* (2014) and online, op ed. type articles such as Chase Strangio's 2016 Slate article *What is a "Male Body"*. This provided trans perspectives outside of the academy and outside my participant group which greatly enhanced my understanding of the topic. Finally, I returned to the literature after the viva, particularly focussing on various methodological texts in order to strengthen the methodology chapter and clinical texts to add a further perspective to some of my arguments. As the literature is so diverse I have decided not to include a separate literature review chapter but rather to begin with a background and history chapter to familiarize the reader with some of the most crucial basic information and then to weave the rest of the literature review throughout the remaining chapters of the dissertation as it is most relevant.

Interviews

The primary mode of information gathering for this thesis came from listening to the experiences of trans people themselves. To access this information I publicized this study and asked people to get in touch with me if they would like to be interviewed. To publicize the aims of the study and my contact information I posted flyers (Appendix C) in trans spaces in London including CliniQ, the trans sexual health clinic, and Open Barbers the queer friendly barber shop. I also announced it at trans support groups and posted on trans Facebook groups. Over the course of this PhD I interviewed nine people for a total of ten interviews. I had one follow-up interview with a respondent who had a lot of stories to tell and was very generous with his time. All of the interviews lasted around 45 minutes to one hour and I audio recorded and later transcribed them all. The interviews were very loosely structured. I began by asking all participants the same identifying information (age, race, pronouns, and gender) to get a better understanding of the makeup of my participant pool. It was important to this study to allow the participants to describe themselves in their own words, particularly when it came to their gender. I tried to encourage people to take as much time as they needed to describe their gender so they would not feel rushed or pressured into using only one or two words. I specifically asked them how they would “describe” their gender and said something along the lines of “however long that takes you to do” or “take your time”. I would then explain to them that I was interested in their experiences with healthcare and would get them started by asking them to describe their most recent experience of accessing healthcare. When at different points in the interview they finished talking and I did not have any more follow up questions based on what they had already told me, I would ask about their experiences with different healthcare providers including being misgendered in healthcare settings, with accessing transition related healthcare, particularly positive or negative experiences with the NHS or private healthcare, and how being trans impacted their health and healthcare. Of these I would only raise the topics that had not already come up in the interview. At the end of every interview I asked participants if they had anything else they wanted to tell me, in order to give them the opportunity to tell additional stories they had thought of. In some cases these were not strictly related to healthcare, such as with Flora who discussed their university course and Ben who talked about his filmmaking projects.

Transcription

While initially transcribing from the recorded interview, I did a verbatim transcription in a dialogue style including all repeated words, filler words, pauses, etc. I did not edit the transcriptions so interviewees for whom English is not their first language or who speak a different dialect of English from me would still have their words portrayed exactly as they were said to me. For any brief pauses of one second or less I put a comma. I have also inserted more commas after the fact in addition to other punctuation to make the quotes more readable. Pauses between one and five seconds I noted with “*pause*” and pauses longer than five seconds with “*long pause*”. Filler words, especially “um” and “uh”, which were present in the original transcription have also been removed in the quotes as they appear in this dissertation for clarity. All other removals of words or sections within quotes are marked with “…”.

Data Analysis

I chose to use exclusively qualitative methods as the best way to capture this kind of complex human experience. As Alan Bryman says in *Social Research Methods*, qualitative methods emphasize words in data collection and analysis, “predominantly [emphasize] an inductive approach to the relationship between theory and research, in which the emphasis is placed on the generation of theories”, and “[embody] a view of social reality as a constantly shifting emergent property of individuals’ creation” (2004, pg. 20). For these reasons, a qualitative approach lends itself perfectly to research seeking to focus on a specific social experience through the lenses of individuals who have that experience. Having the voices of trans people, both through direct quotes from participant interviews and written works but also via my own voice as the author, is critical to the ethics of this research. It would not be a truly collaborative project with these communities without allowing them to tell of their experiences in their own words. Furthermore, this methodology allows the participants to contradict each other and to disagree with me[23]. It allows me to see patterns and nuance in the participants’ experiences because they have been relayed in great detail and I had the opportunity to ask follow up questions. While I do see a need for more quantitative research in this area, particularly a national census that accounts for gender diversity and gender history, the questions of this particular project—what barriers are put between trans people and their healthcare and how do trans people overcome those barriers (if they are able to at all)?—were for my purposes best answered with qualitative methods.

Thematic Analysis

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[23] Indeed it also allows for other scholars to disagree with me. This is a methodology, not a theory. It is an approach to research which will result in a multitude of perspectives. Not all trans scholars (nor indeed all trans people) will come to the same conclusions on any matter. However, with a diverse range of trans voices participating in the discussion, it is my hope that we can move toward the development, implementation, and testing of ever improving models for trans healthcare.

In general, thematic analysis takes a qualitative data set and “focuses on identifiable themes and patterns of living and/or behavior" (Aronson, 1995, pg. 2). However this is a broad term and there are many nuanced ways to embark upon thematic analysis. As I discussed in the introduction, I approached this project using a multi-disciplinary lens. This extends to my application of thematic analysis as well. There is merit to being methodologically open and picking and choosing the best elements for the given problem, “good data analysis (and research design, for that matter) combines appropriate elements and techniques from across traditions and epistemological perspectives” (Guest et al., 2012, pg. 3). In this spirit I combined techniques that I have used on other projects within various disciplines to arrive at this thematic analysis approach.

Once I had my raw data (interview transcripts) I read through them all twice[24] and coded them based on theme. I am using Braun et al.’s understanding of themes “as reflecting a pattern of shared meaning, organized around a core concept or idea, a central organizing concept" (2019, pg. 3). In this light I looked for patterns in the data, ideas or experiences that came up in more than one interview and/or that had also appeared in the literature. I kept separate documents containing all the interview excerpts that dealt with each of the themes which allowed me to analyze the various core concepts. The themes I used were:

- Gender identity
- Sex and bodies
- GICs
- GPs
- Other healthcare providers
- Private healthcare
- Accessing healthcare (barriers and techniques)
- Transition related healthcare
- Non-transition related healthcare

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[24] I read through the transcripts twice during the coding process but as I conducted and transcribed all the interviews myself, by the time I got to the coding stage it was my third and fourth encounter with the material so I was already very familiar with it.

- Gender attribution (including passing and misgendering)
- Mental health
- Bureaucracy
- Time/waiting
- Space/place
- Social media
- Teaching and learning.

While I chose some of these themes in advance of the interviews based on my prior knowledge of the field, others, in the spirit of grounded theory[25], came out of the interviews themselves. Therefore my approach is primarily inductive, data-driven analysis informed by some deductive understandings of what the salient themes may be based on my own experiences as a trans person. Some information overlapped, for example Ben's story about being refused a GIC referral by his GP was categorized under both GPs and accessing healthcare. It was in reading through these themed sets of excerpts, combined with the foundational reading I had done, and my own experiences, that I began to see patterns worthy of further analysis emerge.

Autoethnography

In addition to the experiences I learned about through interviewing other trans people I also gained knowledge from my own experiences through autoethnography, which is the application of self-reflection on personal experiences to broader (in this case) sociological themes and theories. When describing the task of autoethnographers Carolyn Ellis, a scholar whose body of work has focused on creative qualitative research methods and storytelling, explains that:

> "first they look through an ethnographic wide angle lens, focusing outward on social and cultural aspects of their personal experience; then, they look inward,

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[25] I follow Charmaz in understanding grounded theory methods as "consist[ing] of systemic, yet *flexible* guidelines for collecting and analyzing qualitative data to construct theories from the data themselves" (2014, pg. 1, my emphasis). While my analysis methods could not be completely inductive because of my prior familiarity with the field, the majority of themes came out of and all of the findings are firmly rooted in the data.

> exposing a vulnerable self that is moved by and may move through, refract, and resist cultural interpretations." (2004, pg. 37).

Autoethnography is not unidirectional but requires a constant back and forth process of reference — both between the personal and the theoretical and between the individual and the community — that I have incorporated into this work.

On a very basic level, autoethnography can be described as using the lens of one's own lived experience to study sociocultural phenomena, what Boylorn and Orbe call "cultural analysis through personal narrative" (2016, pg. 17). Each of those two factors, cultural analysis and personal narrative, must be present to have autoethnography. Cultural analysis without personal narrative is just traditional ethnography. Equally, personal narrative without cultural analysis is simply autobiography. As Heewon Chang explains in *Autoethnography as Method,* "[s]temming from the field of anthropology, autoethnography shares the storytelling feature with other genres of self-narrative but transcends mere narration of self to engage in cultural analysis and interpretation" (2016, pg. 43). Chang goes on to explain that "… autoethnography should be ethnographic in its methodological orientation, cultural in its interpretive orientation, and autobiographical in its content orientation" (2016, pg. 48). This is the combination of elements I have employed in the dissertation, although I have also used other, non-autoethnographic data as explained above.

Why Autoethnography?

In general, autoethnography has many methodological advantages. Chang describes three main benefits of autoethnography: that "it offers a research method friendly to researchers and readers", that "it enhances cultural understanding of self and others", and that "it has a potential to transform self and there to motivate them to work toward cross-cultural coalition building" (2016, pg. 52)[26]. As for myself, I was first drawn to autoethnography through a discomfort with trying to speak for people with vastly different lived experiences from my own, particularly those who experience oppression that I do not experience. As Tony Adams describes in *Autoethnography: Understanding Qualitative Research*, "[a]s a researcher, I am confident about my right (and privilege!) to speak for myself, but I am less confident about my right to speak on behalf of others" (2015, pg. 12). Rather than going out to study an "other", autoethnography allows a researcher to give others (readers) a glimpse into their world. It "is predicated on the ability to invite readers into the lived experience of a presumed 'Other' and to experience it viscerally" (Boylorn and Orbe, 2016, pg. 15). The value of giving readers that visceral experience is crucial for a project such as this that serves not only as educational material but also as a call to action.

I have specifically incorporated autoethnography into this work because, as a critical method, it is particularly useful for understanding systems of power and oppression and illuminating ways for addressing those systems. As Boylorn and Orbe note:

> "We talk about autoethnography as a critical method by using three central features of critical theory, which include: to understand the lived experience of real people in context, to examine social conditions and uncover oppressive power arrangements, and to fuse theory and action to challenge processes of domination" (2016, pg. 20)

As these three features were already aims of the project as a whole, autoethnography was a perfect fit. The use of autoethnography also impacts the way the work is written.

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[26] Chang also warns of the following pitfalls of autoethnography, "(1) excessive focus on the self in isolation from others; (2) overemphasis on narration rather than analysis and cultural interpretation; (3) exclusive reliance on personal memory and recalling as a data source; (4) negligence of ethical standards regarding others in self-narratives; and (5) inappropriate application of the label 'autoethnography'" (2016, pg. 54). I have tried to be cognizant of all of these throughout this research particularly in relation to consulting with other community members to combat isolation of the self, writing about experiences as they were happening whenever possible, and tying every narration into a larger framework of interpretation.

My use of autoethnography in this work has greatly influenced the trans writing style I have employed; as Gergen and Gergen describe in *Ethnographic Representation as Relationship:*

> "In using oneself as an ethnographic exemplar, the researcher is freed from the traditional conventions of writing. One's unique voicing—complete with colloquialisms, reverberations from multiple relationships, and emotional expressiveness—is honored. In this way the reader gains a sense of the writer as a full human being" (2002, pg.14)

Similarly, in *The Blackwell Encyclopedia of Sociology*, Stacy Holman Jones describes autoethnographic outputs as texts that "feature concrete action, are reflexive and self-critical, and strive to create an emotionally and intellectually charged *engagement* of selves, bodies, texts, and contexts" (2007, pg. 231, original emphasis). By making the most of the emotive and conversational writing style that is achieved with autoethnography I hope to convey my findings in a way that connects with the reader and incites them to engage with the topic.

An Autoethnography of Always

Many of the insights that I have found particularly valuable throughout this research come from the fact that as a member of the group I am researching I share many of the experiences the participants are describing. In order to position myself as an insider researcher[27], I found it necessary to acknowledge and gain knowledge from my own experience as a trans person. In doing so I am following a common disciplinary practice. In *Understanding Trans Health: Discourse, Power and Possibility*, British trans studies scholar Ruth Pearce notes that "expertise was historically located not simply in the medical professions, but also within the detached perspective of *non-trans* writers" (2018, pg. 31). Similarly in *Mutilating Gender*, American legal scholar and trans activist Dean Spade recognizes that "[in] most writing about trans people, our gender

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[27] I am using Nancy Naples' understanding of insider research which defines it simply as "the study of one's own social group or society" (2003, pg. 46)

performance is put under a microscope to prove theories or build ‘expertise’ while the gender performances of the authors remain unexamined and naturalized” (2000/2013, pg. 316). The mere fact of my being a trans person writing about trans people does not inherently avoid this pitfall. However, by specifically addressing my own experience with and relationship to gender alongside the experiences of the participants I hope to produce a work that is collaborative rather than exploitative. In the Introduction to “Mutilating Gender” in the Transgender Studies Reader, Susan Stryker and Stephen Whittle remark that Spade’s “refusal to feign a disinterested distance from the topic of his analysis, his explicit articulation of his embodied stake in the matter at hand, and the knowledge gained from his own embodied situation all exemplify important methodological hallmarks of transgender studies” (2013, pg. 315). Following them, Australian trans health scholar J.R. Latham states that “trans studies as a critical field insists on the author taking account of oneself…the very emergence of trans studies hinges on explicitly prioritising the work of trans people and taking our experiences seriously” (2017, pg. 180-181). Like Latham, I understand this practice within the framework of autoethnography but with a unique application. What I offer here is not an autoethnographic perspective of a specific moment, event, or trauma. It is an autoethnography of always. It is about what I have experienced in the past, throughout and as a result of going through the process of this dissertation, and my hopes for the future. It means when the participants describe their experiences to me, they land with additional emphasis because I have experienced the same or similar things or can imagine with clarity the possibility of those things happening to me. I am also able to write about these experiences with that same clarity which benefits the reader[28]. The participants have certainly illuminated new perspectives and experiences beyond what I would be able to personally share, but nevertheless my understanding of these concepts comes from a place of close proximity.

I made the decision not to separate out the autoethnographic component into its own chapter or into separate sections within the chapters because my experience is not any more interesting or important than that of anyone else. I aim to treat my own

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[28] I have already discussed how autoethnographic writing benefits the reader’s experience of the work above.

narratives in similar ways to those of other participants in this study and have woven my experiences throughout when they are relevant, as I have done with the experiences of the other participants. The interviews informed by the trans methodology outlined above and these autoethnographic elements combine to form the rich data set that will be referenced throughout the rest of this dissertation.

Chapter 2: Background and History

In this chapter I provide the background information required to fully understand the remainder of this thesis. This consists of identifying and defining key terms, discussions of intersex variations, anti-trans violence, and how I understand the scope of health as a concept. I then transition into a section on trans history[29]. I am only able to give a brief selection of a much deeper history within the confines of this thesis, but I start with the work of Dr. Magnus Hirschfeld, an early advocate for gender diversity, and the experiences of Michael Dillon and Roberta Cowell, two of the first people in the U.K. to have genital reconstruction surgery. Then I give the relevant history of the NHS and its policies up to this point and finish by detailing the WPATH Standards of Care.

Language

Etymology of Trans

The terminology used throughout this dissertation can be difficult to definitively define. Different terms have been used to describe trans people throughout history and different people today use some of these terms in unique ways to define themselves. Any definitions I put forth are only relevant at a population level, as individual use of the same terms may vary greatly[30]. I have no authority to give any of these existing terms a definitive definition, nor to apply them to any individual, rather I will recount a brief etymology of the terms as they have generally been used historically and explain how I will be using them.

In *Traversing the Transcape: A Brief Historical Etymology of Trans Terminology*, media studies scholar Mary Alice Adams pulls from multiple sources to create a timeline of the appearance, growing popularity, and subsequent decline of different terms used

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[29] The history provided here is limited to a brief history of trans people as they appear in scholarship but of course trans and gender diverse people have existed long before scholars and medical professionals began writing about them.

[30] For example, one interview participant does not identify as a trans man, he simply identifies as a man. However he is still able to participate in this study because he falls under the trans umbrella when looked at from the broad view, or as he puts it he is a “man with a trans history” (Adam). Using these umbrella terms is an imperfect way to tackle the necessary task of discussing a group of people without purporting to be able to label any individual within that group.

to describe trans people. While the term that is commonly used as an umbrella term has changed over time, none of these terms are obsolete and many people still use all of the terms I will discuss below to identify themselves.

Initially transness was exclusively conflated with sexual orientation, a mistake made by German psychiatrist Dr. Richard von Krafft-Ebing in their 1893 work *Psychopathia Sexualis*. The first breakthrough in developing a language to describe trans people came in 1910 when German sexologist Dr. Magnus Hirschfeld coined the term *transvestite*. This word pattern continues so it is useful to note that the Latin root *trans* means to cross over or to be on the other side of while *vestibus* means clothes so the term *transvestite* is specifically referring to dressing in the clothes usually associated with a gender other than the one assigned at birth. A more modern equivalent would be the term *cross-dresser*. This is still distinct from drag performers[31] who adopt gendered dress specifically for the purposes of performance and entertainment. While Hirschfeld also used *transvestite* to refer to people who sought a medical transition, this ceased with the emergence of the terms *transsexual*, first coined by medical practitioner David O. Caldwell in their 1949 article *Psychopathia Transsexualis*.

Using the term *transsexual* as the default descriptor was popularized by sexologist Dr. Harry Benjamin in the 1950s. This is also where we see the emergence of FTM (female to male) to denote trans men and MTF (male to female) to identify trans women. To return to the Latin roots, *transsexual* means to cross over sex which connotes a physical bodily change. However, initially it was used as an umbrella term, encompassing anyone who had a gender identity that differed from their biological sex, whether or not they had or even wanted to have sex reassignment surgery (SRS).

By the late 1970s, there were several alternative terms. In 1965, psychiatrist Dr. John F. Oliven used *transgenderism* to specifically differentiate between people who “changed” genders and also people who “changed” sexes through SRS. Activist Virginia Prince used the term *transgenderal* to refer to non-op trans people in the late 1960s and in the mid-1970s Ariadne Kaye and Phyllis Frye were using the term *transgenderist*. By

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[31] While some drag kings, drag queens, and other drag performers may also be trans, the identity of transness and the activity and/or vocation of drag, while often conflated, are not in fact correlated and so it will not be discussed at any length here.

the 1980s however, the term *transgender* had taken hold as an umbrella term and is still used quite broadly.

Transgender, meaning to cross over genders, is a bit more vague and therefore is used to encompass cross-dressers, trans people who have SRS, non-op trans people, non-binary people, and anyone else who blurs gender identity lines in one way or another. In other words, a transgender person is someone who has a gender identity different from the one usually associated with the sex they were assigned at birth[32]. The shortened version of *transgender*, *trans*, is also used as an adjective in combination with other words, for example the terms trans man and trans woman. The term *trans** came about in the 1990s in an attempt to account for the growing understanding of gender diversity (Adams 2015). While *transgender* (or its shortened version *trans*) can include non-binary people, *trans** was meant to be more explicitly inclusive of those identities. However it has largely fallen out of favor in recent years.

I will be using *trans* throughout this dissertation as a general term to discuss myself, the people who have participated in this study, and everyone else this work applies to. I will be using *cisgender,* or *cis* for short, to discuss everyone else who this study does not pertain to, i.e. people who have a gender identity that is usually associated with the sex they were assigned at birth.

Pronouns

As noted above, all people mentioned throughout this work will be referred to by the pronouns they use themselves. Where their pronouns are unknown, the gender neutral singular “they” pronouns are used so as to not misgender[33] anyone. Additionally, several people whose pronouns are known simply use the singular they pronouns so the use of the singular they does not necessarily indicate that the referent’s pronouns

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[32] This is not the shortest way to explain this but I have chosen this language carefully to be as accurate as possible. Terms like “born male” or “natal gender” do not resonate with trans people who see themselves as having been born their true gender (i.e. trans women who identify as having been born female, just with a different than expected body). To say “gender identity different from the gender assigned at birth” is not fully accurate as it is sex that is assigned at birth based on genital appearance, not gender. Saying “gender identity different from the one usually associated with the sex they were assigned at birth” highlights the false deterministic relationship assigned to these two factors. I will go into this in more detail about this relationship in Chapter 3.

[33] To misgender someone is to refer to them using gendered language (such as “sir” or “she”) that does not align with their gender identity.

are unknown[34]. All participants were asked at the start of their interview for their pronouns so they are referred to in the way that they have selected. For authors and theorists I am discussing, it is less simple. The traditional method of guessing at someone's pronouns based on the culturally gendered associations of their name would be at odds with the goals of this work. Therefore, wherever possible, I have reached out to the person to ask for their pronouns and in some cases, particularly with trans scholars, they have made their pronouns clear within their work. In the case of historical theorists I am exclusively using the gender neutral pronouns because it is not possible to inquire about their pronoun preferences or gendered experience[35].

There are many other gender neutral pronouns, such as zie/hir[36], xe/xem, fae/faer, ey/em, it/it, etc., but I have chosen they/them as the go-to gender neutral pronoun for this work because the singular they is fairly common in the English language already (although it often goes unrecognized)[37] and the plural version is frequently used by English speakers. While its use is gaining popularity, particularly in trans and queer communities, it may be difficult for some readers less familiar with the use of the gender neutral singular "they". At first glance to the uninitiated a sentence like "in their 2001 paper…" will seem to be talking about a paper with two or more authors, and indeed it may be. The plurality of the "they" must be determined from the context. Language, when intentionally and politically deployed, need not be easy to understand. In fact it is particularly important to note that gender neutral pronouns are not easy to understand or commonly used, which is difficult for many trans people looking to represent themselves and to see themselves properly represented in language. I do not disrupt the flow of my writing for some readers lightly, but rather hope that they will participate in

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[34] I myself use the pronouns they/them.

[35] This is with the slight exception of a few historical trans figures who have made their pronouns clear in their autobiographies.

[36] This format of subject pronoun/object pronoun is a common way to denote one's pronouns. It is also common to extend the format to subject pronoun/object pronoun/possessive adjective, for example they/them/their. Sometimes people will say things like "my pronoun is they" or "I use male pronouns" to simplify it further expecting the addressee to understand what that means and be able to extrapolate the rest of the pronoun cases. Typically the possessive pronoun and reflexive pronoun, for example "theirs" and "themself" (a more singular alternative to themselves) respectively, are omitted but not necessarily.

[37] A 2012 post by Catherine Soanes on the Oxford Dictionary Blog has a further analysis on this subject with historical examples that may be useful: http://blog.oxforddictionaries.com/2012/06/he-or-she-versus-they/.

doing the work of normalizing gender neutral language. With greater familiarity the moment of confused pause upon encountering the use of the singular they will hopefully diminish and eventually disappear.

It may seem appropriate to simply use the gender neutral pronouns universally, to refer to everyone as “they”, however I have not done this out of respect for many of the trans people I am discussing. To ignore the wishes of trans people who have explicitly told me or otherwise made public their pronouns would be no better a strategy than guessing people’s pronouns. Sometimes called “degendering”, this process of using gender neutral terminology is only applicable up to the point where you do not know which gendered terms an individual does and does not want to use for themselves[38]. Once that information is known, to then ignore it denies the individual that ability to self-identify which is so crucial for many trans people. For example, intentionally referring to a trans woman who has had to fight for her recognition as a woman and has stated she uses she/her pronouns as “they” would be denying her womanhood in a way that can be just as dismissive as intentionally referring to her as “he”. Thus I only use gender neutral pronouns for people who explicitly use those pronouns or in cases where I do not know what pronouns someone uses.

In addition to pronouns, titles or honorifics are another area where non-binary and other people not wishing to declare their gender struggle. In the past some people simply used “M.” but currently the gender neutral title “Mx.[39]” is gaining popularity. It is an accepted title on many government forms in the U.K. and is being adopted by more and more businesses, universities, etc.

Other Terminology

In addition to terminology specifically describing trans people, there is terminology in the upcoming sections that may be new to some readers outside trans communities or unfamiliar with the field of trans studies. I will define some of those terms as I will be using them here as a general guide for the reader, however, once

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[38] Some people use multiple pronouns (for example “she/her or they/them”), some use any pronouns, and others use no pronouns at all or “name only”.

[39] Pronounced /məks/ or /mɪks/ (English Oxford Living Dictionaries).

again, these are not conclusive definitions. Language is constantly changing, as we have seen with the history of terminology for trans people, and different people may use or not use certain terms for themselves for various reasons. To this end, definitions of more specific gender identities are absent although their meaning and usage will be explored throughout the dissertation in relation to the identities of interview participants. It is best practice to allow people to explain and describe their gender in their own words which all informants for this dissertation have been given space to do.

I have already mentioned *cisgender*. Essentially the opposite of the root *trans*, the Latin root *cis* means on this side of or on the same side of, so the term *cisgender* refers to people who have a gender identity that matches the one usually associated with the sex they were assigned at birth, such as someone who was assigned female at birth and identifies as a woman. The shortened form, *cis*, can also be used. This terminology was first coined by biologist Dana Leland Defosse in 1994 to draw attention to the universality of gender identity and to the fact that it is not just trans people who have a gender identity and need language to describe it (Adams, 2015, pg. 178).

I have also mentioned non-binary people. This is a term under the trans umbrella[40] but is also an umbrella term itself. In the U.K., and of course more broadly, babies are assigned one of two sexes at birth, male or female. Even babies who are neither of these two sexes are forced into one category or the other, which I will discuss further in the section on intersex people. These two sexes are then conflated with genders to form the gender binary, the incorrect assumption that everyone is either male or female. Some trans people identify within the gender binary, as male or female[41], however some people are neither, both, shift around, have no gender, or have a completely different gender not related to male or female: the possibilities are vast. These people are who I am discussing when I use the term “non-binary”.

Another way to categorize within the trans umbrella is with the terms *transfeminine* and *transmasculine*. *Transfeminine* can be used to describe AMAB[42] trans people which includes binary trans women as well as non-binary trans women and other

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[40] Although not all non-binary people identify as trans.

[41] Although some people identify as non-binary males or non-binary females.

[42] Assigned Male At Birth.

AMAB non-binary folks. *Transmasculine* on the other hand refers to AFAB[43][44] trans people including binary trans men, non-binary trans men, and other non-binary people who were assigned female at birth. These are extremely useful terms for being able to include non-binary people. For example, when explaining who seeks testosterone, being able to say “transmasculine people” rather than just “trans men” is more accurate and inclusive. However, these terms come with their own set of problems. They do not account for AMAB trans people who are and/or present in more masculine ways and AFAB trans people who are and/or present in more feminine ways as well as those people who are and/or present equally masculine and feminine in their gender identity or who may identify completely outside those concepts. It creates a false connection between the relative femininity and masculinity of someone’s gender identity in relation to the perceived relative femininity and masculinity of the sex they were assigned at birth. The language becomes conflated because masculine and feminine and their counterparts male and female are used to in English to refer to sex and bodies, gender, clothing, other methods of gender expression, and social roles. The AMAB/AFAB framework is not ideal either, as it does not perfectly allow for intersex people[45]. I will use *transmasculine* and *transfeminine* carefully throughout with the intention of being more inclusive of non-binary people, but if I were to say, for example, “many transfeminine people seek estrogen”, I am not implying anything about this group’s bodies, gender roles, or gender expressions. I am simply trying to refer to all people who may want estrogen and cannot make enough of their own. It is my hope that as the language used in trans studies and by trans communities continues to evolve that better and more accurate terminology will develop.

Transitioning is a term commonly used to discuss the process of “changing” from one gender to another or as Ruth Pearce describes it:

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[43] Assigned Female At Birth.

[44] AMAB and AFAB are terms that are commonly used within trans communities, particularly online.

[45] Although intersex people are generally assigned either male or female at birth.

> "Transition refers to a move away from the gender that was assigned to a person at birth, and towards to an alternative preferred, desired or felt state of gendered (or non-gendered) being" (2018, pg. 4).

I will problematize this term and question its relevance later but this is how it is commonly used. There are also different categories of transitioning such as *social transition*, which refers to people changing things like their name, pronouns, and outward gender expression, and *medical transition*, where people seek hormone replacement therapy and different surgical procedures in order to be more comfortable in their bodies. I will also differentiate between "transition related healthcare" to refer to all healthcare needs that trans people have specifically because they are trans and "non-transition related healthcare" to refer to all other healthcare needs they have that are not specifically trans related.

Passing is another relevant concept. This refers to being seen as a certain gender by most people most of the time. It is usually used in the context of trans people passing as their actual gender, for example a trans woman who is correctly gendered by strangers, who generally "looks like a cis woman"[46], and who is not identified by people who don't know her status as trans, is said to "pass". Although they were discussing intersex people[47], American sociologist Harold Garfinkel defines someone's passing as "the work of achieving and making secure their rights to live in the elected sex status while providing for the possibility of detection and ruin carried out within the socially structured conditions" (1967/2006, pg.60). So passing is that state which grants a trans person ease of movement through society but carries with it the specter of being "found out". People know they are passing based on different gendered social cues such as being called "sir" or "ma'am", the pronouns people use to talk about them, and not being questioned on their gender.

Additional Background

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[46] These are scare quotes meant to challenge the idea that it is at all possible to look like a cis woman as there is no one way that cis women look.

[47] The work that this quote is from is in fact about a trans woman, however at the time of writing it Garfinkel and the rest of the researchers working on this case believed the subject to be an intersex person so that is the perspective they were writing from.

Intersex

Intersex people have and will continue to be mentioned throughout the course of this dissertation because their existence refutes sex binaries that impact trans people as well[48]. While not the focus of this thesis, it is important to outline a bit about them and the interesting ways they factor into trans studies. One of the first orders of business after a baby is born is to tick off “m” or “f” on the basis of genital appearance, but with some intersex babies that becomes a difficulty[49]. Intersex people have characteristics used to determine sex, mainly genital appearance, the internal reproductive system, hormone secretion, and the 23rd chromosomal pair, which do not all fit into the same one of two boxes. This can manifest in many different ways but some of the possibilities are: androgen insensitivity syndrome where people have XY chromosomes but develop “female” external genitalia, congenital adrenal hyperplasia where people have XX chromosomes but increased androgen production leading to genitalia that appears “male”, Klinefelter syndrome where someone who is usually assigned male has an extra X chromosome (XXY), Turner syndrome where someone usually assigned female is missing an X chromosome (X), and Rokitansky syndrome where people are usually assigned female based on their XX chromosomes and external genitalia but have a shorter vagina and no cervix or womb (NHS Choices: Disorders of sex development[50]). All of these ways of being intersex show that sex is more complicated than a simple male-female binary.

Biological sex is clearly more than just “male” and “female”, but the sex binary is so deeply ingrained that standard practice since the relevant medical technology has been available has been to give infants “corrective” genital surgery as described below by gynecologist Sarah Creighton in the Journal of the Royal Society of Medicine:

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[48] Of course intersex people can also be trans.

[49] This is not the case with all intersex people, as it is not always apparent at birth and some people are not aware of being intersex until later in life and indeed some people may never know they are intersex.

[50] NHS Choices is part of the NHS’s official website and provides free information including explanations of health conditions, healthy living tips, health related news, information about health services and specific care providers, and social care information.

> "Clinicians aim to choose the gender that carries the best prognosis for reproductive and sexual function and for which the genitalia and physical appearance can be made to look most normal. It is thought this will ensure a stable gender identity. If surgery is required, it is performed as soon as possible and no later than 24 months." (2001, pg. 218)

In their 2006 article *Consensus statement on management of intersex disorders*, Hughes et al. further illuminated the perceived need for expediency as well as the criteria used to make the gender assignment:

> "Initial gender uncertainty is unsettling and stressful for families. Expediting a thorough assessment and decision is required. Factors that influence gender assignment include the diagnosis, genital appearance, surgical options, need for life long replacement therapy, the potential for fertility, views of the family, and sometimes the circumstances relating to cultural practices" (pg. 556).

This is a multitude of diverse factors and itself complicates any notion that sex identification is a straightforward matter. The input of the parents and even cultural practices (they later allude to the stigma in certain cultures around female infertility) are cited here as medically valid reasons to commence medical procedures that in adulthood would be considered "sex reassignment" or a medical gender transition. The gender identity and gender expression of the individual are notably absent as factors on assigning the "sex of rearing" as it is called in many of these documents. Even convenience factors are addressed, with Hughes et al. stating that "feminising as opposed to masculinising genitoplasty requires less surgery to achieve an acceptable outcome and results in fewer urological difficulties" (2006, pg. 558). A key problem is that this is framed as an immediate issue requiring immediate intervention, and so the individual may be too young to have formed a gender identity or to be consulted.

The theme throughout the medical literature on intersex people is that it having an intersex variation is definitely a problem, something to get to the bottom of. "If the appearance of the external genitalia is sufficiently ambiguous to render sex assignment impossible or the phenotype is not consistent with prenatal genetic tests, *then de facto, extensive investigation is required*" (Ahmed et al., 2011, pg. 14, my emphasis). There is no interrogation here as to why not being able to easily tick 'm' or 'f' on the birth certificate is so distressing. Why is it that rather than conceive of a third or many more sexes these infants are operated on to normalize their bodies? Or, as American philosopher and gender scholar Judith Butler asks, “are these bodies subjected to medical machinery that marks them for life precisely because they are ‘inconceivable’?” (2001/2006, pg. 187). Creighton goes on to unpack a lot of the controversy surrounding this practice and shows how the tides were beginning to change for the treatment of intersex infants in the early 2000s.

> “Until lately, genital surgery has been seen as the mainstay of treatment but recent evidence suggests that this is not so. Adult patients are unhappy and feel mutilated and damaged by surgery performed on them as young children, however worthy the clinician's motives. Although the technology for investigation and diagnosis of these conditions is improving rapidly with advances in biochemical and genetic testing, there are still few long-term data on the results of intervention. Clinicians working in this field must step back and review their practice. Surgery may not be necessary. We need much more information to allow clinicians and parents to make informed decisions, and for this purpose multicentre research on long-term outcomes is essential.” (Creighton, 2001, pg. 219-220)

Hughes et al. recognize that “medical interventions and negative sexual experiences may have fostered symptoms of post-traumatic stress disorder” and that intersex people may very well present as a gender different from the one chosen for them once they are old enough for gender identity to emerge (2006, pg. 558).

Whether or not these early surgical interventions are still standard practice in the U.K. is more difficult to answer. The literature that is linked to by the NHS for parents of intersex children walks them through the entire process of diagnosis, dealing with friends and family, psychological support, and so on but stops just short of explaining the actual treatment guidelines and how they can expect to navigate that process (Ellie and Achermann, 2014). Nonconsensual genital surgeries are still being performed on children, however, activism by intersex people has lead to an increased awareness of the harm of this practice amongst medical professionals. Liao et. al. address this new ground in a 2015 British Medical journal article calling for a review of surgical interventions and the formation of non-surgical care paths. They note that “gender assignment has become less simplistic but normalising surgery remains common” and specifically that “the rate of female assigned and surgically feminised children who reassign as male is of concern” (Liao at. al., 2015). There is definitely overlap with a discussion of trans health here as those “surgically feminized children” who identify as male may have a trans experience. The two groups are also undergoing many of the same “treatments” including genital reconstruction surgeries and hormone replacement therapy.

These treatments for intersex children are consensual under current U.K. law because parents have been granted the legal right to consent by proxy. Infants are by definition unable to give consent to any procedure. Further, the particular procedures I am discussing here are neither medically necessary nor time sensitive. Thus there is no need to perform them before the individual is old enough to give informed consent. This understanding of these procedures—as nonconsensual— comes from a human rights perspective which may be used as a basis to challenge current law. This idea is expanded in Garland and Slokenberga, 2019.

The Scope of ‘Health’

As may already be apparent, what is considered to be relevant to trans health is considered very generously here. Of course there are those specific transition related healthcare needs such as hormones, a myriad of surgeries, gender-specific psychotherapy, and so on. Then there are the auxiliary health challenges that are unique to trans people but are not transition related such as men requiring pap smears and women who need prostate exams. Then there is every other healthcare need that any person could have in their lifetime but which can be complicated by someone’s trans status. But in addition to these there are also public health factors to consider. Trans people are at a high risk for physical and sexual assault, murder, and suicide; they experience discrimination in education, housing, and employment, and they often lose close ties to friends, family, and community (see Lombardi et al., 2002; Stotzer, 2009; Lee and Kwan, 2014; Talusan et al., 2016; Clements-Nolle et al., 2006; Whittle et al., 2007; Bradford et al., 2013; Badgett et al., 2007; and Kreiss and Patterson, 1997). All of these factors can lead to poor health outcomes (see Cutler and Lleras-Muney, 2006; Schanzer et.al., 2007; Jin et al., 1995; Ryan et.al., 2009; and Yadegarfard et al., 2014). These indicators that impact trans people will be considered as part and parcel of health throughout this thesis. It is important to understand trans health beyond the framework of hormone therapy and surgeries as well as beyond the clinical encounter.

> “health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma.” (WPATH, 2011, pg. 1-2)

I will employ this shift in focus throughout this thesis in order to give a broader and more informative view of trans health.

Violence

To expand upon this particular public health factor, it is important to understand how and why violence disproportionately impacts trans people. Trans women are particularly at risk, especially from straight, cis, men who are attracted to them (Factor and Rothblum, 2007; Greenberg, 2012; Testa et al., 2012; Lee and Kwan, 2014). In such an encounter, upon discovering that a woman is trans, the man reacts violently, an outward expression of internalized homophobia. This reaction is later explained at trial with the so-called “trans panic defense”. In murder trials across many legal systems, the killer can be acquitted or found guilty of a lesser charge if they can show that the victim provoked them[51]. In murder trials where trans women are the victims and cisgender men are the perpetrators, this “trans panic defense” has emerged: “the defendant claiming this defense will say that his discovery that the victim was biologically male provoked him into a heat of passion and caused him to lose his self-control” (Lee and

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[51] In the U.K. specifically if “a person (‘D’) kills or is a party to the killing of another (‘V’), D is not to be convicted of murder if—(a) D's acts and omissions in doing or being a party to the killing resulted from D's loss of self-control, (b) the loss of self-control had a qualifying trigger, and (c) a person of D's sex and age, with a normal degree of tolerance and self-restraint and in the circumstances of D, might have reacted in the same or in a similar way to D…For the purposes of subsection (1)(a), it does not matter whether or not the loss of control was sudden…A person who, but for this section, would be liable to be convicted of murder is liable instead to be convicted of manslaughter” (Coroners and Justice Act 2009, s 54). Those qualifying triggers could be “D's fear of serious violence from V against D or another identified person”, "a thing or things done or said (or both) which—(a) constituted circumstances of an extremely grave character, and (b) caused D to have a justifiable sense of being seriously wronged”, or both (Coroners and Justice Act 2009, s 55).

Kwan, 2014, pg. 77). Here the perpetrator reads the victim as female until they see the victim's genitals, wherein "finding out that he had been attracted to a person with a penis made him doubt his own masculinity and heterosexuality" resulting in the physical assault and sometimes murder of the trans woman (Lee and Kwan, 2014, pg. 111). This feeds into a narrative of trans people as being deceitful, that because these women have "male bodies", by presenting as women they are lying or hiding something.

Exact statistics on these crimes are difficult to ascertain. The majority of research that is available is from the United States and even that data is limited. On the most basic level, we do not even know how many trans people there are in the U.K. The English census[52] does not contain any questions about trans status or gender identity and only allows two options under the question "What is your sex?", "male" and "female", so non-binary people are completely erased (Office for National Statistics, 2011). Without clear statistics on the size of the trans population it is difficult to situate statistics about hate crimes against trans people. A clear picture of the size and makeup of the trans population in the U.K. would show if the statistics that are available about violence against trans people are definitively higher in relation to the percentage of the population they represent than for the general population or other groups. For some perspective, a project by reporters from Mic[53] called "Unerased: Counting Transgender Lives" which has compiled a database of every documented murder of a trans person in the United States since 2010 (the first year data was available), has organized some of the key data that has been collected on this subject. This information is not available in a more formal format. Since "no government agency consistently tracks violence against transgender people, the job is left to a decentralized and largely informal network of LGBTQ organizations and activists to account for trans murder in America" (Talusan et al., 2016). In their analysis using estimates for the United States trans population they found that young[54] Black trans women have a one in 2,600

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[52] The most recent census was in 2011 and the next one will be in 2021. The Office for National Statistics has received feedback on this issue and is considering adding more options to the 2021 census to more accurately capture gender identity (Office for National Statistics: Gender identity).

[53] Founded in 2011, Mic is a New York based online journalism organization (Mic About Us).

[54] Young people is defined as anyone aged 15-34.

chance of being murdered compared to a one in 12,000 chance for all young people and a one in 19,000 chance for the general population (Talusan et al., 2016).

The Unerased project also highlights a further issue which is that these statistics represent only the documented cases. If a trans person is murdered, they need to be identified as a trans person before they can appear in any data. Perhaps the trans person had not come out to many people, perhaps their family does not accept that the victim is trans and misgenders them in death. Police and other authorities may not recognize the victim as trans, for example reporting that a victim is male because they have a penis without noticing or understanding the significance of factors such as hormone levels, gender presentation, or the person's self-identification on their social media. For this reason Talusan et al. believe that there are potentially many more murders of trans Americans than are currently known.

For some data that is more geographically relevant to this dissertation, the organization Transgender Europe's Trans Murder Monitoring Project has recorded 2,264 murders of trans people worldwide since they started the project in 2008, and this is not counting the many people who survive their attacks (TvT research project, 2016). Here in the U.K. the annual Home Office report regarding hate crime statistics, where "hate crime is defined as 'any criminal offence which is perceived, by the victim or any other person, to be motivated by hostility or prejudice towards someone based on a personal characteristic" (Corcoran et al., 2015, pg. 2), found 555 hate crimes against trans people in England and Wales for the 2013/2014 period (Creese and Lader, 2014) rising to 605 for the 2014/2015 period (Corcoran et al., 2015). However they estimate a total of 222,000 hate crimes across all of the monitored strands[55] occur every year but only 52,528 were reported to police in the 2014/2015 period, leaving over 150,000 estimated hate crimes unreported each year (Corcoran et al., 2015). Thus the surface has really only been scratched with this data[56]. The very lack of data itself paints the trans population as one that is consistently overlooked, but these findings that are starting to come to the fore along with the personal experiences that many trans people

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[55] The five currently monitored strands are race, religion, sexual orientation, disability, and transgender identity.

[56] See also Turner et al., 2009.

share of violence and harassment, highlight that this is something that must be considered when attempting to address the behemoth issue of trans health.

History

Early Understanding

Dr. Magnus Hirschfeld, an early sexologist and advocate for gay and trans people in Germany, represents a crucial turning point in the modern history of transness. They founded the Scientific-Humanitarian Committee, the world's first gay rights organization[57], in Berlin in 1897. They coined the term *transvestite* while also recognizing the limitations of that term with the hope that a better one would emerge. They identified as gay themselves and actively advocated for the repeal of Paragraph 175, Germany's anti-gay law. This anti-gay law impacted trans people as well because at that time in the early 1900s a straight trans woman for example would have been seen as a man in the eyes of the law so her having sex with men would be illegal. This is still an issue in many countries to this day.

Their pioneering 1910 work, The *Transvestites: The Erotic Drive to Cross-Dress*, reads in many ways as far ahead of its time. It espouses many of the same ideas and offers similar recommendations to contemporary trans studies literature. It is in this work that they propose their theory of sexual intermediaries to explain the, as they saw it rather common, phenomenon of sexual diversity. "By sexual intermediaries we understand…-and their number is not limited-ones who stand, in the physical or mental view, between a complete manly man and, in every respect, a womanly woman" (Hirschfeld, 1910/2006, pg. 35). This intermediariness could be in one, several, or all of four of the following categories: the sexual organs, the other physical characteristics, the sex drive, and the other emotional characteristics. We still use these same four categories today only we may call them genitalia and other reproductive organs, secondary sexual characteristics, sexual orientation, and gender identity.

Variations in the sexual organs accounts for the diversity that is intersex people (Hirschfeld used the term *hermaphrodite*). Variation in other physical characteristics

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[57] At the time there was little distinction between gay people and trans people so while it was a "gay rights organization" many gender non-conforming people took part as well.

include people assigned female at birth who grow beards and people assigned male at birth with pronounced breast tissue. These characteristics can be linked to being intersex as well but not in every case. Variations in sex drive would result in people who are homosexual, bisexual, or otherwise non-heterosexual. Hirschfeld further includes people who transgress traditional gender roles in their sex lives, so men who enjoy being submissive and women who like to dominate. Variations in the final category of other emotional characteristics are where this dissertation is primarily focused. These are the people who would today include trans and other gender non-conforming people.

People can of course encompass any or all of these variations in different ways and to different degrees. The possibilities for diversity are endless. Hirschfeld even questioned if it was possible to not have any of these variations whatsoever.

> "Accordingly, a complete womanly and 'absolute' woman would be such a one who not only produces egg cells but also corresponds to the womanly type in every other respect; an 'absolute' man would be such a one who forms semen cells yet also, at the same time, exhibits the manly average type in all other points. These kinds of absolute representatives of their sex are, however, first of all only abstractions, invented extremes; in reality they have not as yet been observed, but rather we have been able to prove that in every man, even if only to a small degree, there is his origin from the woman, in every woman the corresponding remains of manly origins" (Hirschfeld, 1910/2006, pg. 35).

They are claiming that in fact no one is free from variations in these categories. While perhaps people who have enough variation in any one category to identify themselves (or be labeled) with a particular identity are in the minority, the experience of diversity within sex and gender is a fundamentally human one.

This represents a radical shift in sexology and the as yet undefined field of trans studies. They maintain that there is something inherent about masculinity and femininity while completely divorcing those concepts from having any explicit link to biological sex, gender identity, sexual orientation, or gender expression. This allows for the validation of endlessly diverse genders, sexes, sexual orientations, and any combination thereof. This early work laid the crucial groundwork for Benjamin, Kinsey, and other key theorists. Unfortunately this progress was perhaps too groundbreaking for its time. With the rise of fascism in Germany, Dr. Hirschfeld, who in addition to being gay was also

Jewish and a scientist outspoken on controversial issues, was specifically targeted by Nazi groups. They were forced into exile by 1932 and in 1933 the Nazis raided Hirschfeld's Institute for Sexual Science in Berlin where much of their archives were publicly burned. They died in exile in France in 1935 at the age of 67 (Djajic-Horváth, 2014).

Trans in the U.K.

Just a few years after Hirschfeld's death, the first known transition in the U.K. began. In 1938 Michael Dillon, a young Oxford educated man from Kent, procured testosterone pills, the first known case of someone taking the drug for the purpose of "changing" genders. With the effects of testosterone he was easily able to pass and enrolled in medical school and became a physician himself. As someone who suffered from unrelated hypoglycemia, in the early 1940s he fainted and was taken to the Royal Infirmary in Bristol. It was there while being treated for the head injury he sustained during his fall that he met one of the world's early plastic surgeons. This plastic surgeon performed a double mastectomy on Dillon and referred him to another surgeon, Sir Harold Gillies, for further surgeries. Gillies, often considered the father of plastic surgery, developed their surgical expertise treating soldiers during World War I who returned from war with facial and other deformities sustained in battle (Kennedy, 2008).

The first woman to undergo SRS in the U.K. was Roberta Cowell, a friend of Dillon's. She considered herself quite different from Dillon however, as she was adamant that there was a physical basis for her femininity. She differentiated herself from "transvestites" like Christine Jorgensen (who she understood as men who just wanted to be women) and herself, who was, she believed, intersex. In fact she spoke quite negatively of homosexuals and "transvestites". She described herself as transitioning "from just being a female to becoming a proper woman" (Cowell, 1954, pg. 153). Due to certain feminine secondary sex characteristics, particularly a feminine fat distribution, she was able to begin a course of hormones which she took for two years without a social transition. At that point she was able to legally be declared female and have her birth certificate amended. Then in 1951 she had a vaginoplasty performed by

Sir Harold Gillies followed by facial cosmetic surgery[58] and a third operation on her genitals which she described as a “tidy-up”. She was only legally able to obtain these procedures because she obtained a diagnosis of intersexuality. She socially transitioned after her surgeries, which were a success, and passed away in 2011 at the age of ninety-three (Bell, 2013).

Healthcare in the U.K.

The National Health Service

While not every healthcare interaction in the U.K. takes place within the National Health Service (NHS), it is the crux of the British medical system. Any changes made to private care would only impact the small number of people who can afford and choose those services and such changes would be decentralized while changes to the NHS have the potential to impact a much greater number as any resident is eligible to receive those services free at the point of care. The NHS was first instituted in 1948 beginning at a single hospital in Manchester providing medical, dental, and optical care entirely funded through taxation[59] (NHS history, 2018) meaning that, ideally, people only pay what they can afford through their relative tax rate which is in turn based on income[60]. The National Health Service and Community Care Act of 1990 saw the formation of NHS trusts, a group of organizations within the NHS serving a wide range of specialized functions. In 2013 the NHS was restructured so more of the specialities that were previously managed by their own trust now fall under foundation trusts. These foundation trusts serve a geographic area rather than a specific speciality and are independent entities that can raise and manage their own funds and are beholden to a board of governors rather than government regulation. Some trusts dealing with specialized care do remain in place, specifically ambulance services, community health, and mental health, however many mental health services are now being merged under foundation trusts (NHS authorities and trusts, 2016).

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[58] What we would today call facial feminization surgery or FFS.

[59] Today there are aspects of healthcare including dental, eye care, and prescriptions which are supplemented through taxation but do incur some cost to the individual at the point of care.

[60] Although this did not eliminate class-based health inequalities, see Gray, 1982.

The history of the NHS is long and rich but here I will highlight only those few developments that are relevant to this thesis. In 2008, the concept of free choice was introduced, allowing patients who are seeking a referral from their GP for specialist care to choose any care provider or hospital that meets the NHS standards of care (Thorlby and Gregory, 2008). This means that trans people seeking a referral to a GIC from their GP do not have to be referred to the clinic that is geographically closest to them[61]. In 2009 the health secretary pledged to eliminate "mixed sex" hospital accommodation by the following year, thus making all accommodation "single-sex" (Beasley and Flory, 2009). This was intended to ensure "privacy" and "dignity" but creates problems for trans people who want to be housed according to their gender identity and people who do not fit into binary sex and/or gender categories. Also in 2009 the NHS Constitution was published, outlining the rights patients have and what they should expect and demand from their health services. This includes a maximum eighteen week wait time[62] from the day you are referred by a GP to beginning specialist treatment. Currently, no GICs are meeting this standard, with the longest publicized wait time being thirty months from referral to first appointment. In 2012 the Patient Choice Scheme was launched as well as measures to increase the boundaries for GP practices (Department of Health, 2012). This means patients potentially have more GPs to choose from. For a trans person this is crucial, because if their request for a referral to a GIC is denied by one GP and/or they experience negative treatment from their practice, they have more GPs to choose from and can transfer and try again. Also in 2012 the NHS Mandate[63] was first published. This mandate was updated in 2013 and is organized around the key areas of "preventing people from dying prematurely", "enhancing quality of life for people with long-term conditions", "helping people to recover from episodes of ill health or following injury", "ensuring that people have a positive experience of care", "treating and caring for people in a safe environment and protecting them from avoidable harm", "freeing the NHS to innovate", understanding "the broader role of the NHS in society",

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[61] I go into more detail around the process of making this choice in Chapter 4.

[62] The NHS constitution has been updated a few times (most recently in 2015) and it no longer specifically states this eighteen week minimum wait time however the NHS continues to refer to this standard across much of their other literature.

[63] This is only applicable to NHS England.

“finance”, and “assessing progress and providing stability”. I will examine how the NHS has achieved some of these standards in relation to trans people throughout this dissertation.

Commissioning Practices

Within the NHS, “Commissioning is the continual process of planning, agreeing and monitoring services” (What is commissioning?, 2019). It is how the NHS decides what services are needed and who will provide those services and in what ways. While the NHS directly commissions primary care services[64] and some specialist services, most specialist and community services are commissioned by Clinical Commissioning Groups (CCGs).

NHS England commissions three components of service on what they call the “gender dysphoria pathway”. These three components are the youth service which includes therapeutic and endocrinological care for people under the age of 18, gender clinics for adults[65] “offering assessment, diagnosis, overall care coordination, hormone treatments, voice and communication therapies and talking therapies”, and surgical services for adults (Gender Dysphoria, 2019).

Program Board

In 2014 NHS England’s Specialised Commissioning Oversight Group established the Task and Finish Group for Gender Identity Services to respond to “long-standing concerns about poor patient access and patient experience, inconsistent and inequitable approaches to commissioning and delivery of these services, and excessive waiting times” (NHS, 2020, pg. 2). These continuing issues, particularly as highlighted by the 2016 parliamentary inquiry into transgender equality, led to the Task and Finish Group being replaced by a Gender Identity Programme Board in 2018. This board’s stated aim is “[t]o lead the review of specialised gender identity services across England, having regard to the impact of decisions to the populations of Wales, Scotland and Northern Ireland where necessary” (NHS, 2020, pg. 2). Additionally there is a

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[64] Although GP practices can be co-commissioned with CCGs and GP surgeries belong to a CCG.

[65] People can be referred to an adult clinic from the age of 17.

Clinical Reference Group (CRG) made up of five medical professionals which advises the board. In 2019/2020 the board has set the following goals:

> “Oversee the process of awarding contracts for the provision of specialised services for adults (surgical; and non-surgical) through a process of competitive procurement…[u]se procurement to consider designation of one or two Gender Dysphoria Clinics to function as a National Trans Health Unit, having responsibility for managing a national or supra-regional network of Gender Dysphoria Clinics…[e]stablish a pioneering gender dysphoria service in a community or primary care setting in Greater Manchester, as a pilot for evaluation; and consider pilots for other models for delivery in other parts of the country…[e]stablish a National Referral Support Service to assist individuals in choosing a surgical provider that can best meet their objectives…[e]stablish a new quality framework that requires designated providers to report meaningful clinical indicators, and that includes Patient Reported Outcome and [e]xperience Measures (co-designed with people with lived experience)…[r]eview the service specification and clinical commissioning policy for the Gender Identity Development Service for Children and Young People” (Gender Dysphoria Clinical Program, 2019).

These bodies set the remits and policy for NHS commissioned gender identity services and are generally responsible for transition related healthcare[66].

Remits of the Gender Identity Clinics

The NHS has different service specifications for each of the three components of the gender dysphoria pathway: children services, adult non-surgical services, and adult surgical services.

Children’s Services

Although this research is focused on adults and none of the participants have been seen by any children’s services, it is still useful to the whole picture of transition related healthcare to address what those services do. In England children and adolescents are referred to the Gender Identity Development Service (GIDS) to access

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[66] While not specifically policy, there are also other groups that have produced various guidance documents that clinicians can reference when providing care, such as the *Good practice guidelines for the assessment and treatment of adults with gender dysphoria* by the Royal College of Psychiatrists (2013) and *Trans: A practical guide for the NHS* by the Department of Health (2008).

transition related healthcare. These services can see young people up to their 18th birthday, although as mentioned above people can be referred to the adult service from the age of 17. The service is staffed by a multidisciplinary team including mental health professionals and social workers, pediatric endocrinologists, administrators, and nurse practitioners who assist with social transition and prescribe hormone blockers (and in some cases HRT for older patients). The specific remits of GIDS are:

> “to provide specialist assessment, consultation and care for children and young people, including psychological support and physical treatments, to help reduce the distressing feelings of a mismatch between their natal (assigned) sex and their gender identity. The service will also provide support to the family or carers of clients…[t]he psychological element of the service is a Tier 4 mental health service which will support children and young people to understand their gender identity” (Stocks, 2019, pg. 1).

The service draws on the WPATH SOC, National Institute for Health & Care Excellence (NICE) guidelines for the treatment of mental health, and other emerging best practice evidence.

Adult Non-Surgical Services

Non-surgical services for adults in the U.K. fall under the responsibility of the various GICs. Each GIC has a senior clinical lead that heads a multidisciplinary team with expertise in mental health and social support, endocrinology, voice and communication, trichology, administration, and generally all the health needs that someone accessing transition related healthcare may have. The specific non-surgical services offered can include talking therapy, HRT, facial hair removal, voice therapy, and support with social transition (Gender Identity Services for Adults: Non-Surgical Interventions).

Adult Surgical Services

Surgical interventions are provided by specialists surgical teams, based in hospitals across the country, who are commissioned outside the structure of the GICs, although the GICs refer people to these surgical teams. If there is more than one team performing the required procedure, the individual can request which team they want to be referred to. Each surgical provider has a senior clinical lead that heads a multidisciplinary team with expertise in the particular surgical techniques they offer, anesthesiology, radiology, nursing, administration, and any other skills that are relevant to the procedures they perform. The procedures that are commissioned by the NHS fall under two categories, chest surgeries and genital surgeries. The standard chest procedures that are commissioned are double mastectomy (double incision or peri-areolar technique), masculinizing chest liposuction, nipple repositioning (including pedicled flaps), nipple grafting, nipple-areolar complex modification, dermal implant, and nipple tattooing. The standard genital procedures that are commissioned are various types of phalloplasty, metoidioplasty, urethroplasty, scrotoplasty including testicular prosthesis, hysterectomy, bilateral salpingo-oophorectomy, vaginectomy, placement of and training in the use of penile prosthesis, glans sculpting, penectomy, bilateral orchidectomy, vaginoplasty, clitoroplasty, and vulvoplasty. Procedures that are not routinely commissioned include phonosurgery, augmentation mammoplasty, facial feminization surgery, thyroid chondroplasty, rhinoplasty, lipoplasty/contouring, microdermabrasion, general “cosmetic” procedures, body hair removal that is not on a surgical donor site, hair transplantation, or the reversal of any procedures accessed as part of the gender dysphoria pathway. Additionally, hysterectomy, bilateral salpingo-oophorectomy, penectomy and orchidectomy are not commissioned as stand alone procedures, therefore accessing any of these procedures without a concurrent phalloplasty, metoidioplasty, vaginoplasty, or vulvoplasty requires the approval of the individual’s CCG for funding (Gender Identity Services for Adults: Surgical Interventions).

This is the care that is within the remits of the NHS commissioned GICs. If someone is seeking care that falls outside of this specification they will have to either apply to their local CCG for funding or access it through a private provider.

Clinician’s Perspectives

In this section I will highlight some perspectives from a few clinicians who work with trans people in the U.K. However this will necessarily be brief and non-exhaustive as the focus of this dissertation is on trans people's experiences of healthcare so any in depth analysis of clinicians is beyond the scope of this work. This is not to position trans people and clinicians as opposing groups, as Richards et al. have pointed out, "[i]t is important to acknowledge the multiplicity of identities most people inhabit and to recognize that being 'trans' or a 'clinician' are not mutually exclusive categories." (2014, pg. 250). Indeed one of the participants in this research is themselves a clinician. It is simply to say that the focus is on trans people's experiences of accessing and receiving healthcare, not on the experiences of people providing healthcare whether they are trans or not. Within the literature written by people in their role as clinicians I will focus on those contributions that are most relevant to the issues discussed in this thesis. In his foreward to *Transgender Health: A Practitioner's Guide to Binary and Non-Binary Trans Patient Care*, Dr. Stuart Lorimer (currently of London's Tavistock and Portman GIC) calls for medical care providers to familiarize themselves with trans healthcare, saying ""[w]e, as a profession, no longer have the luxury of treating trans as an esoteric little micro-speciality" (2018, pg. 12) and "...it is the duty of every medical practitioner to manage gender-related issues safely and effectively" (2018, pg. 13). While I am focusing on the work of clinicians who specifically provide transition related healthcare here, Dr. Lorimer's point, that providing high quality healthcare for trans people is the remit of all medical care providers regardless of their field of practice, is important to note[67].

Some clinicians actively challenge the gatekeeping practices that trans people face when accessing (specifically transition related) healthcare[68]. Dr. Walter Bouman, Dr. Christina Richards, and Prof. Jon Arcelus, three clinicians from the Nottingham GIC, along with many international colleagues have questioned the need for two referrals, or "signatures", for lower surgery in their 2014 paper *Yes and yes again: are standards of care which require two referrals for genital reconstructive surgery ethical?*. As that paper states,

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[67] Clinicians are also engaged in educating their colleagues outside of GICs, for example with Ahmad et al.'s *Gender dysphoria services: a guide for general practitioners and other healthcare staff* (2013).

[68] I will discuss these gatekeeping practices further in subsequent chapters, particularly Chapter 4.

> "The purpose of the second opinion is not discussed or clarified in any of the current [Standards of Care], despite the fact that obtaining the second opinion can cause delays in treatment, especially in sparsely populated areas, and may be seen by some as unduly invasive. Indeed, in the broader field of medicine aside from trans services, there are very few cases in which two opinions for physiological interventions are required and those which do mostly involve people who lack capacity to consent to treatment or people who are seen outside of a multidisciplinary team." (Bouman et al., 2014, pg. 379)

They highlight that concerns such as the irreversibility of the procedures and the "loss of healthy tissue" are often cited as a reason for needing two signatures for lower surgery. However, they counter that,

> "[a] further argument…is that of the number of signatures required to allow other irreversible elective surgeries such as live kidney donation, and cosmetic facial, breast and genital surgery, for example. In such cases (when not related to gender dysphoria), either a single or no psychiatric or psychological opinion is required, often at the discretion of the operating surgeon" (Bouman et al., 2014, pg. 381).

Bouman and Richards also note in a 2013 paper that "[i]t is significant that, with the exception of some neurosurgery for psychiatric symptoms, no other surgical intervention requires the production of two written opinions" (pg. 169). These gatekeeping practices are currently required of clinicians but those cited here (and likely other colleagues of theirs) are challenging their necessity and usefulness. Another factor that restricts clinicians' practice is the fact that care provided on the NHS is publicly funded. As Bouman et al. explain,

> "it is important to note that there is a key difference between privately and publicly funded health care. In the former, an absence of harm from treatment may be sufficient, provided the person accessing the intervention is making an informed decision. In the latter, there must be a demonstrable positive benefit of treatment for patients. This is because those paying for interventions for others (tax- payers) rightly expect their money to have been put towards some practical end and not merely be used to fulfil a desire on the part of the person seeking services" (2014, pg. 378)

All of these restrictions limit what clinicians are able to accomplish under current conditions, however it is clear they do not always agree that the ways in which they have to operate are necessarily best practice.

Clinicians have also shown support for depathologization and potentially even demedicalization[69]. Bouman and Richards have acknowledged that "...while diagnostic terms facilitate clinical care and access to insurance coverage for mental health difficulties in the USA and some other countries, these terms can also have a stigmatising effect" (2013, pg. 165). This is elaborated further in the 2015 paper *Trans is not a disorder – but should still receive funding* which is authored by Dr. Richards, Prof. Arcelus, Dr. Bouman and Dr. Lorimer as well as Dr. James Barrett, Dr. Leighton Seal, and Dr. Penny Lenihan of London's Tavistock and Portman GIC and Dr. Sarah Murjan of the Nottingham GIC. In this paper, they challenge the need for medicalizing transness with a diagnostic label while acknowledging the specific regulations that bind their practice, namely that they currently cannot provide many treatments without a diagnosis. They explain their position thusly:

> "at present, the healthcare funding systems in many countries are set up in such a way as to make it effectively impossible to assist trans people with hormones and surgeries if they do not have a diagnosis which relates to those interventions" (Richards et al., 2015, pg. 310).

They go on to provide an alternative, depsychopathologized model for trans healthcare which I will discuss more in Chapter 4 and which my own argument for demedicalization expands upon. Because they are constrained by these regulations, they specify that "the political end of removing diagnoses in their entirety is not worth the extraordinary risk of removing the provision of treatment for trans people until such time as alternatives have been put in place" (Richards et al., 2015, pg. 311). This idea of timing is absolutely crucial and I completely agree with the assessment that any depathologization or demedicalization process must come along with changes regarding the regulations that dictate clinician's practices to ensure there is no loss of access for hormones and surgeries. Finally, they sum up their argument as follows:

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[69] A full discussion of depathologization and demedicalization can be found in Chapter 4.

> “The final question which presents to us, then, is: is diagnosis a useful frame within which to conceptualise trans experience? We submit that it is not. Diagnosis is still necessary for funding and sundry bureaucratic matters, but it is a poor method of understanding the complex interplay of biology, psychology, personal and social influences which form this complex topic; and especially the complex interplay of such elements in any given trans person. Our clinical experience is that understanding and assisting with these elements and the interplay within them is of far more use than the rather procrustean approach of “fitting” a given trans person within a diagnostic box and potentially dismissing the elements which do not comfortably fit…We will, of course use diagnosis for pragmatic ends to assist the trans people who see us, but, to help, not to label, and given the long history of pathologisation, and longer history of diversity never as a de facto understanding that trans people are disordered” (Richards et al., 2015, pg. 311).

While they are currently restricted by existing policies and regulations, these clinicians understand the importance of removing limiting and pathologizing diagnostic labels and are working to imagine a future where the care they provide is not limited by such constraints. As Dr. Richards and Dr. Lenihan along with two colleagues in academia state:

> “In our experience, [clinicians] rarely relish the exercise of power, or the role of ‘gatekeeper’, but they do acknowledge the responsibility of ensuring that people recognize the decisions they are making and so are truly able to give informed consent.” (2014, pg. 255)

Private Healthcare

It is important to note that private healthcare continues to be an option for those who can afford it in the U.K., and trans people know this option well. One of the main advantages of “going private” as it is called is that the wait times are significantly shorter. For trans people who are struggling with long waiting lists to receive care (this is discussed at length in Chapter 5), going private can get them started on their transition sooner, something that can save lives. One participant, Dan, discussed how his NHS referral process was initially held up through some clerical errors. Once he was on the waiting list, he endured the estimated wait time he was initially quoted but still had not received a letter with an appointment date. When he was finally able to get a more realistic estimate for his first appointment date, which at that time was seven to eight months from the referral, he decided he could not wait that long.

> “there was a complete meltdown and a reevaluation cause at that point everything was being held back because I was gonna get seen and something was gonna start moving and just the thought that it wasn't gonna be moving forward just kind of threw me into not a great place” (Dan)

He reassessed his finances and sought private care. Within a month he was starting testosterone, a huge difference from people’s experience getting hormones through the NHS. He went private for his double mastectomy as well, but the obvious downside to this is financial. Dan’s initial consultation cost around £260, then there were four counseling appointments at £75 apiece, another £260 appointment, and £180 for a three month supply of testosterone. Between the counseling required to access hormones, hormones themselves, and double mastectomy surgery, Dan estimates he is about £8,000 in debt. He is currently struggling with the wait for phalloplasty but says he absolutely has to go through the NHS for that because he cannot afford another private procedure. So while it is a costly option and a less common one, private healthcare is still a route some trans people take and is a factor to consider when trying to understand the full picture of trans healthcare in the U.K.

Standards of Care

Both NHS and private healthcare providers have a few key sources of guidance on how to treat their trans patients. One is the ‘Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People’ which is published periodically by The World Professional Association for Transgender Health (WPATH)[70]. WPATH is a non-profit “international interdisciplinary, professional organization” that aims “to promote evidence based care, education, research, advocacy, public policy, and respect in transgender health” (WPATH: Mission and Vision). The Standards of Care (SOC) is a 68 page document, currently in its seventh version (2011[71]), advising

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[70] Formerly The Harry Benjamin International Gender Dysphoria Association.

[71] The first version was published in 1979.

medical professionals on how to treat gender dysphoria[72]. It differentiates gender dysphoria from gender non-conformity where the latter is simply diverging from the expected gender performance usually associated with the sex you were assigned at birth and the former is the specific discomfort and distress that those people may or may not experience as a result of their being gender non-conforming and/or trans. There is only the briefest mention of genderqueer and other non-binary trans people but all the recommendations made in the SOC are specifically targeted for either trans men or trans women. Thus this document presents a basic treatment outline which consists of changing one's gender expression or socially transitioning, hormone replacement therapy, surgeries (chest[73] and genital[74] as well as facial and other bodily surgeries), and psychotherapy[75]. In addition it recommends non-medical social support for trans people such as online support groups, community organizations, and resources for friends and family[76]. In the following sections I summarize the specific recommendations put forth by the SOC. In later chapters I will unpack and indeed critique and disagree with some of these recommendations but what follows is the opinion of WPATH as it appears in this document.

Requirements and Responsibilities for Medical Professionals

The guidelines recommend that mental health professionals[77] working with trans people, in addition to a cultural competency around trans issues, have the minimum requirements of a master's degree (or equivalent), familiarity with the DSM and/or ICD, the "ability to recognize and diagnose co-existing mental health concerns and to

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[72] This document is based largely on information and studies from Europe and North America so they recognize that their recommendations may need adapting in different cultural contexts.

[73] Colloquially referred to as "top surgery".

[74] Colloquially referred to as "bottom surgery" or "lower surgery".

[75] These SOC "apply to all transsexual, transgender, and gender nonconforming people" (WPATH, 2011, pg. 67), and they specifically state that they still apply to trans people who are in prison or are otherwise institutionalized and specific accommodations should be made to insure these people are safe.

[76] Also often referred to as SOFFAs which stands for 'Significant Others, Family, Friends, and Allies'.

[77] The types of mental health professionals are defined to include people with training in "any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling" (WPATH, 2011, pg. 22).

distinguish these from gender dysphoria", "documented supervised training and competence in psychotherapy or counseling", knowledge "about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria", and that they seek further education on these topics[78] (WPATH, 2011, pg. 22). They also recommend some competency with sexuality and sexual health. The tasks assigned to these mental health professionals are to evaluate patients to determine whether they have gender dysphoria, if they determine their patient to have gender dysphoria to provide them with information on the medical interventions they may be able to seek, and identify and treat any mental health issues they may have that are unrelated to their gender dysphoria. Additionally they are able to make the decision to refer someone for hormone therapy and different surgeries. At that stage they initiate professional relationships with other medical professionals and it is suggested that they work openly and closely with those professionals. While the SOC does not make any specific recommendations for psychotherapy, they recognize that it can be a valuable asset to trans people especially during periods of transition in their lives as well as family therapy and even online therapy. They also go so far as to position mental health professionals as key trans advocates who should work to educate their colleagues, people in the field of medicine more broadly, and people in other fields such as education and human resources.

Medical Interventions

The SOC also addresses the specifics of care that are provided by GPs, surgeons, and other medical professionals not specifically specializing in mental health. They are very clear in the document about first offering trans people different options to maintain their reproductive capabilities before they begin hormone therapy or more importantly have surgery. People who produce sperm can have it frozen and stored. As the presence of estrogen diminishes sperm count, it is suggested that sperm retrieval and storage be done before beginning hormone therapy or when hormone therapy has been paused to allow the sperm count to recover. People with egg cells can have their

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[78] They recognize that this quality of mental health professional is not available or accessible to everyone. They suggest distance therapy using various technologies as a possible solution and urge insurance companies in countries without universal healthcare to cover these treatments.

eggs retrieved and stored but the process is much more complicated and physically taxing[79].

Another consideration outside the traditional hormones and surgery framework is voice therapy. Here trans people "seek the assistance of a voice and communication specialist to develop vocal characteristics (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication patterns (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity" (WPATH, 2011, pg. 52). These voice therapists and other professionals should meet similar requirements to those for mental health professionals working with trans people. The focus with this type of therapy should not be on shoehorning everyone into a singular trope of masculine or feminine communication but rather individualized therapy to help trans people find their authentic voice and communication style that helps them feel at ease with their gender expression[80].

Hormones

Hormone therapy is described as a medical necessity but the SOC specifies that "hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues" (WPATH, 2011, pg. 33). More specifically, the criteria for accessing hormone therapy are "persistent, well-documented gender dysphoria", that the person can legally and mentally[81] provide informed consent for the treatment, and that "if significant medical or mental health concerns are present, they must be reasonably well- controlled" (WPATH, 2011, pg. 34). Hormones may not be denied to people based on prior self-medication with unprescribed hormones nor on the basis of seropositivity but medical professionals may deny hormones if there will be a danger to

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[79] For this reason some transmasculine people simply forgo reproduction altogether or put off lower surgery and come off their hormones to become pregnant themselves.

[80] Vocal masculinization is a side effect of testosterone so transmasculine people may not require this service. There is also the option for vocal feminization surgery for transfeminine people but there is still limited research on that procedure.

[81] Specifically they state that "no surgery should be performed while a patient is actively psychotic" (WPATH, 2011, pg. 62) and mental health professionals should work with the trans person to try and improve psychiatric disorders with therapy and/or medications.

the person because of a medical condition. There are many possible health risks that can accompany hormone therapy so the SOC recommends regular follow-ups with primary and psychological care providers and monitoring through laboratory tests. It also suggests more education for primary care providers as to the effects and possible risks of hormone therapy and allows for a few exceptions to the rule of clinicians requiring a referral from a mental health professional providing a diagnosis of gender dysphoria before prescribing hormones. If someone comes to them and is already on hormones, whether prescribed by another doctor or obtained from other sources (friends, the internet, etc.), the clinician can prescribe them hormones for a limited time (one to six months is recommended) until they can access a long term prescription through the usual channels. This practice is called *bridging* and prevents trans people from having to go off their hormones in these situations. Hormones can also be provided following an oophorectomy or orchiectomy for people who have that procedure before beginning hormones. Cis people who have these procedures are offered hormone replacement therapy so the same care is extended to trans people except with the option to choose between masculinizing and feminizing hormones. The masculinizing hormones are testosterone, sometimes accompanied by progestins to aid in the cessation of the menstrual cycle, administered transdermally in a gel form or intramuscularly with an injection. Oral testosterone is available but it does not have as strong effects as the gel or the injection and is not commonly used in the U.K.. The feminizing hormones are estrogen, most commonly accompanied by some form of anti-androgen, and sometimes (controversially) with progestins.

Surgery

In terms of surgical interventions, these are also necessary for many trans people. The SOC clearly differentiates these procedures from elective cosmetic surgical procedures[82].

> “genital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures. Typical elective procedures involve only a

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[82] Although it is important to note that there is also work challenging the distinction between trans surgeries and cosmetic surgeries (Heyes and Latham, 2018).

> private mutually consenting contract between a patient and a surgeon. Genital and breast/chest surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals" (WPATH, 2011, pg.55).

As with hormones trans people should not be denied surgery on the basis of seropositivity. The surgeon should be collaborating with mental health professionals and hormone prescribing physicians if applicable while also confirming for themselves that those professionals' assessment of gender dysphoria is correct. Having done this, the surgeon should then discuss the different surgical options, highlighting the respective pros and cons, risks, and limitations in order to help the trans person decide which surgery/surgeries are right for them and obtain informed consent. While the surgeons should be clear about the possible risks, it is noted that "even patients who develop severe surgical complications seldom regret having undergone surgery" (WPATH, 2011, pg. 64). As with any surgical procedure the SOC recommends long-term post-operative care and monitoring.

The options for "MtFs" are breast augmentation, genital surgeries including penectomy, orchiectomy, vaginoplasty, clitoroplasty, and vulvoplasty, and other surgeries to correct secondary sexual characteristics such as facial feminization surgery, reduction of the Adam's apple, liposuction and lipofilling to redistribute fat, and vocal feminization surgery. For "FtMs" surgical options include double mastectomy, genital surgeries including hysterectomy, ovariectomy, the construction of a penis through metoidioplasty or phalloplasty, and testicular implants, as well as liposuction and lipofilling. Even within these different types of surgery there are different techniques that will achieve different results[83]. Surgeons would ideally be skilled in multiple techniques but they should discuss their limitations with people seeking surgery from them and be ready to make a referral for another surgeon if the person is seeking a technique or result they feel they cannot deliver. The SOC also recognizes the importance of the internet for trans people to share post-operative photos and advice to help others choose the right surgeon for them.

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[83] The specificities of some of these different techniques will be discussed in Chapter 2.

In order to qualify for chest surgery, they suggest a single referral given on the basis of the presence of gender dysphoria, being legally and mentally able to consent to the procedure, and not having any other health issues that have not been addressed and/or could make it dangerous for the person to undergo surgery. Undergoing hormone therapy is not a requirement however it is suggested that transfeminine people take estrogen for a minimum of twelve months first in order to grow their breasts. For genital surgery, specifically hysterectomy and ovariectomy or orchiectomy, two referrals are suggested. The criteria are the same as for chest surgery with the addition of twelve months of hormone therapy. The rationale for this is so that patients have a twelve month period of the hormones their body produces by itself being suppressed through a reversible treatment before they have irreversible surgery in case they change their mind[84]. For metoidioplasty, phalloplasty, or vaginoplasty, there is a further criteria of "12 continuous months of living in a gender role that is congruent with their gender identity[85]" (WPATH, 2011, pg. 60).

There are no specific criteria for other surgeries that correct secondary sexual characteristics because these surgeries are often considered aesthetic and therefore do not require referral from a mental health professional or a diagnosis of gender dysphoria. The disadvantage here is that these procedures will not be covered under many insurance schemes, including under the NHS. One participant, Emily, explained how she was not seeking chest or genital surgery after getting hormone therapy but instead wanted some of these other procedures that to her were more important to helping her pass in her day to day life.

> "what they provide, I wanted to remain with them in order to ask for things which were on the edge of availability because my needs were different to some others. Living my life…in society, being accepted you know facial appearance

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[84] Although they do state an exclusion for people who can not take hormones for medical or undefined 'other' reasons.

[85] Adding a criteria for one type of genital surgery (genital reconstruction) over another type (gonad removal) will in many cases be meaningless as these two types of genital surgeries are generally only completed simultaneously as I discussed earlier. It would then follow that in order to have the full procedure with both types of surgery one would need to satisfy the requirements for whichever has more criteria, in this case genital reconstruction.

> and facial hair and voice were more important to me and they were unwilling to fund any of those things except for a short course of voice therapy" (Emily)

In her case, procedures like facial feminization surgery, electrolysis for hair removal, and potentially vocal chord surgery would have benefitted her a great deal but she was unable to access these procedures as they are not part of the traditional care path for trans people[86]. The SOC supports this, stating that "these same operations in an individual with severe gender dysphoria can be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation" (WPATH, 2011, pg. 64).

"Real Life Experience"

The reasoning the NHS gives for the requirement of twelve months living in one's gender role to access lower surgery is due to the irreversible nature of the procedures.

> "Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be…the duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings)" (WPATH, 2011, pg. 61).

This experience is to be documented by health professionals working with the trans person and they may request proof such as a deed poll showing a legal name change or talking with people from their life who can attest to their gender presentation.

Standards of Care for Children and Adolescents[87]

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[86] As I discussed earlier in the chapter, facial feminization and vocal cord surgeries are not commissioned by the NHS gender pathway. While facial hair removal is commissioned and some people are able to access it through their GIC, it is not universally available as part of the care path as illustrated by Emily's inability to access it.

[87] See also Vincent, 2018 for a thorough discussion of healthcare provisions for trans children and adolescents in the U.K.

For minors, the SOC specify a separate set of guidelines. Firstly they differentiate between children and adolescents, stating that children who are gender non-conforming will not necessarily grow up to be trans adults. Children experiencing gender dysphoria may grow up to be gay or it may simply disappear. Adolescents experiencing gender dysphoria on the other hand are, as they see it, far more likely to have those feelings persist into adulthood and therefore are more likely to require early intervention and treatment. They assert that mental health professionals working with trans children and adolescents should, in addition to meeting the requirements set out for those working with trans adults, be “trained in childhood and adolescent developmental psychopathology” and ”competent in diagnosing and treating the ordinary problems of children and adolescents” (WPATH, 2011, pg. 13). In addition to similar psychotherapy and social transition[88] that would be offered to adult patients they recommend treating trans adolescents with puberty suppressing hormones[89], a fully reversible intervention. This can be followed with partially reversible interventions, specifically hormone therapy. In many countries hormones can be started at age sixteen years old. After fully reversible and partially reversible interventions (they recommend going in this order), irreversible interventions in the form of various surgeries can be granted although not until the person reaches the age of majority, usually eighteen years of age[90]. Any treatment that tries to change a child or adolescent’s gender identity or force them into a cisgender role has been shown to be ineffective and is unethical.

“Non-Transition Related” Healthcare[91]

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[88] They do not specify the age at which this should occur. They cite insufficient knowledge and research into the effectiveness and outcomes of socially transitioning in early childhood.

[89] Children who go through this process then continue on to seek further transition in adulthood never go through gonadal puberty and therefore they are not able to seek the same reproductive options that are offered to people who begin this process later in life.

[90] Under the NHS people who are seventeen and older can be referred to an adult GIC and can receive all procedures available on that care path (NHS Choices: Gender Dysphoria-Treatment), however with current wait times, someone referred on their seventeenth birthday would not even be seen for their first appointment until after they have turned eighteen.

[91] Again a detailed look at what specific healthcare needs trans people might have in regards to various medical specialties can be found in Vincent, 2018.

In addition to all of the therapies and surgeries described thus far, which could be categorized under “transition related healthcare”, there are other healthcare considerations that are “non-transition related”. These include the unique healthcare needs trans people have because they are trans in addition to healthcare for other medical or mental health conditions as well as general health and well being. Trans people are encouraged to undergo all appropriate health screenings for their age and other individual factors and to follow the associated recommendations. Further, they should be monitored for possible side effects of long-term hormone use and any surgeries they may have had. Cancer screenings can pose a unique challenge as many transmasculine people require breast and/or cervical cancer screenings and many transfeminine people will need prostate cancer screenings. Other urogenital care can be difficult for trans people to bring themselves to access because of being misgendered and/or experiencing genital dysphoria, something care providers should be cognizant of.

Intersex People

This edition of the SOC includes intersex[92] people who have been previously left out of this discussion. They are open to recognizing the increasing number of people who are both trans and intersex and have come to the attention of medical professionals, however they specify that there is a distinction in the diagnosis of gender dysphoria between people who are intersex and people who are not intersex, effectively creating two sub-categories. They recommend thorough scrutiny and a similar care path to those trans people who are not intersex. The main difference in accessing care is that the process can be much quicker. Children can be treated with medical interventions as early as infancy in some cases, “even genital surgery may be performed much earlier in these patients than in gender dysphoric individuals without a DSD if the surgery is well justified by the diagnosis, by the evidence-based gender-identity prognosis for the given syndrome and syndrome severity, and by the patient’s wishes” (WPATH, 2011, pg. 71).

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[92] The SOC refer to them as people with “Disorders of Sex Development” or “DSD” but I will be referring to them by the term “intersex” which is the demedicalized term that intersex rights groups use for themselves. WPATH attempts to reconcile this by stating that they remain “open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery” (WPATH, 2011, pg. 69). Some people also use DSD to mean “Differences of Sex Development”.

They still suggest that people of any age got through a social transition first to acclimate to their gender role however for intersex people the recommended time frame for this is six months rather than the twelve months suggested for people who are not intersex.

Chapter 3: Understanding Sex and Gender

“[T]he task of distinguishing sex from gender becomes all the more difficult once we understand that gendered meanings frame the hypothesis and the reasoning of those biomedical inquiries that seek to establish ‘sex’ for us as it is prior to the cultural meanings that it acquires”
(Butler, 1990, pg. 148-149)

“How, as feminist sociologists, can we conceptualize bodies as socially constructed without viewing the body as floating free of the material actualities of lived experience?”
(Jackson and Scott, 2001, pg. 9)

“Recognising that sex is socially constructed is not to deny that material reality exists — simply that the meaning ascribed to biology occurs as a social process, and this has changed and continues to change over time."
(Vincent, 2018, pg. 45)

Much of the conversation around validating trans people focuses on the difference between sex and gender[93] as concepts and on challenging the limited, binary definition of those two terms (Valdes, 1995). Sex is often framed in a heavily gendered way contributing to a pervasive belief that sex and gender are interchangeable and that sex determines gender. Therefore by clearly separating gender from sex the connection that gender has to the physical is called into question or even disavowed, and this often seems to be the best way to account for trans existence. Judith Butler sums this stance up thusly:

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[93] An example of early work understanding transness through the lens of a sex/gender distinction can be found in Robert J. Stoller’s 1968 book *Sex and Gender: The Development of Masculinity and Femininity* and an important foundational unpacking and questioning of that distinction can be found in West and Zimmerman’s 1987 article *Doing Gender*.

> "Originally intended to dispute the biology-is-destiny formulation the distinction between sex and gender serves the argument that whatever biological intractability sex appears to have, gender is culturally constructed: hence, gender is neither the causal result of sex nor as seemingly fixed as sex." (1990, pg.8)

For example a trans woman may have a "male" body and have been assigned the male sex at birth but because gender and sex are separate concepts her female gender identity validates her as a woman[94]. However, this separation promotes narratives that fail to accurately describe the diverse experiences of trans people. In this chapter I will argue that the best model for understanding sex and gender is in fact to understand them together, as deeply entwined concepts that constantly co-create each other. I begin by looking at how sex is already understood through the lens of gender and the different problematic models for transness that leads to. I then look at how people attribute sex and gender to others which illuminates a lot about how we think about bodies and gender. Looking at some of the specific features that are often used in attribution I question the importance or relevance of attributing sex and gender at all. This does not mean that it is unnecessary to do away with the concept of gender altogether, but by understanding that sex is just as socially constructed and self-identified as gender and how gender and sex influence each other we can better understand the diversity of the embodied human experience[95].

The Egg and The Sperm

The way physical bodies are discussed by medical professionals is often seen as an objective description of reality. However, anatomy and physiology textbooks are not immune to influence from the culture in which they were produced. Social scientists such as Emily Martin have challenged and analyzed the ways in which culture influences science and medicine. This influence is especially clear with scientific

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[94] This concept directly relates to medicalization, where a trans person's sex and gender are seen as being at odds with each other (gender dysphoria) and the treatment is to bring them back into alignment through medical intervention, a model that requires the separation of the concepts of sex and gender. This will be discussed at length in Chapter 4.

[95] It is important to note that all of the concepts discussed in this chapter do not only apply to trans people. Everyone has a body and a relationship to gender but trans experiences highlight these concepts in a unique and productive way.

discussions of bodies and body parts that are strongly gendered, a perfect example being sex cells.

Anthropologist Emily Martin has addressed this topic in their 1991 article *The Egg and the Sperm: How Science Has Constructed a Romance Based on Stereotypical Male-Female Roles*. This feminist critique specifically zeroes in on gametes as a prime example of the way the gendered body is represented and described in scientific literature. As Martin puts it, “In the course of my research I realized that the picture of egg and sperm drawn in popular as well as scientific accounts of reproductive biology relies on stereotypes central to our cultural definitions of male and female” (1991, pg. 485). They explain how, in scientific literature, sperm cells are cast in the role of the brave and daring knight and the egg cell as the damsel in distress, or conversely the egg cell as the femme fatale and the sperm cell as her hapless victim. The metaphors and language used influence the supposedly objective scientific knowledge that is being conveyed. In this example, it was previously thought that the egg played no active role in fertilization, that this “feminine” cell was passive and the “masculine” sperm cells did all the hard work. Biologist and gender scholar Anne Fausto-Sterling[96] noticed the same phenomenon when looking at the history of scientists trying to understand and classify sex hormones: “social belief systems weave themselves into the daily practice of science in ways that are often invisible to the working scientist…gender and science form a system that operates as a single unit—for better and for worse” (2000, pg. 194). Martin is arguing the latter, that this system creates biases that are detrimental to knowledge production. Much more is now known about fertilization and the active role the egg cell plays, and yet that picture can still be lost because of the continued use of gendered language by researchers when describing their findings. They are unable to break away from, firstly, the idea that egg cells are feminine and sperm cells are masculine, and, secondly, that this relates to cultural tropes of femininity as weak and passive and masculinity as strong and active, even to the detriment of scientific accuracy and knowledge production. This highlights the way in which biomedical knowledge cannot be extricated from the culture in which it is produced. Martin hopes

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[96] Fausto-Sterling has also written more recently on biology, childhood, and the development of sex, gender, and sexual orientation. While very interesting, this work is not relevant here as a discussion of how people may become a certain gender is far outside the scope of this work.

that shining a light on the problematic nature of these gendered metaphors will not only improve our understanding of biological processes but “will rob them of their power to naturalize our social conventions about gender” (Martin, 1991, pg. 501)

While a discussion of transness is absent in Martin’s work, I am expanding upon their ideas to better understand how trans people are impacted by the gendering of bodies and body parts. Sperm and egg cells being discussed in this gendered way further reinforces the idea that people who produce sperm cells are male and people who are born with egg cells are female and/or that women have egg cells and men produce sperm cells. This is a particularly important biological stance to unpack as this is one trait that trans people are not yet able to change. For example, some trans women and other transfeminine people will, through accessing transition related healthcare, cease to produce sperm cells, but they will never have egg cells as this is beyond the scope of current medical technology. In the popular and essentialist understanding of female bodies as ones that have egg cells (and everything that goes along with that, i.e. menstruation, pregnancy, etc.), transfeminine people’s absence of sperm cells is overshadowed by their lack of egg cells. Trans men and other transmasculine people may have their ovaries and therefore their egg cells removed but again they are not able to produce sperm cells[97]. This, along with other anatomical markers of transness in genitals and secondary sexual characteristics, leads to the use of terms such as male-bodied and female-bodied and the concepts of a woman being born in and/or trapped in a “male body” and the same for men in so called “women’s bodies”. These terms and concepts rely on that differentiation between sex and gender, validating trans people’s gender by saying that their gender and sex do not match. Philosopher Talia Mae Bettcher explains this phenomenon as such:

> “In what I call the ‘wrong-body’ model, transsexuality involves a misalignment between gender identity and the sexed body. This idea developed in the context of sexology, medicine, and psychiatry (facilitated by technological developments). While in the psychological variant of the model, transsexuality is viewed as a problem of the mind (albeit treatable through sex reassignment surgery) by the

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[97] Some trans people may always retain the gamete production system they were born with meaning they may, for example, both possess egg cells and not produce sperm cells, thereby carrying both gendered signifiers of, in this case, a “female” gamete production system.

> medical establishment, in the wrong-body model proper, transsexuality is viewed as a problem of the body by transsexuals themselves. The wrong-body model proper has two versions. In the weak version, one is born with the medical condition of transsexuality and then, through genital reconstruction surgery, becomes a woman or a man (in proper alignment with an innate gender identity). In the strong version, one's real sex is determined by gender identity. On the basis of this native identity one affirms that one has always really been the woman or a man that one claims to be. In both versions, one is effectively a man or woman 'trapped in the wrong body.'" (2014, pg. 383)

This model has gained a lot of acceptance, including in the NHS. The web page on gender dysphoria says that "adults with gender dysphoria can feel trapped inside a body that doesn't match their gender identity", discusses "biological sex", trans people feeling stigmatized enough to try and "live according to their anatomical sex", and has a video story from a trans woman who they describe as having been "born in a male body", a phrase the subject does not use at any point in the video[98] (NHS Choices: Gender Dysphoria-Treatment). This NHS resource is supporting a "wrong body" narrative both directly through stating it outright and using it to describe their example trans woman, and indirectly through relying on the concepts of "biological" and "anatomical" sex. These concepts imply that trans people's gender may be what they say it is but their sex is something physical that remains unchanged and that despite being a woman a trans woman is "biologically male", is trapped in that "male body", and necessarily seeks to alter it.

Challenging the Narrative[99]

One way to challenge the 'wrong body' narrative is by deconstructing the idea of the gendered body. It is possible that this narrative has been a necessary stepping stone toward a greater acceptance of trans people, but as trans voices are increasingly present in the discussion, that story of being trapped in the wrong body and the concepts of being female-bodied or male-bodied are being disrupted. So while the sex/gender distinction has served trans people well in gaining some degree of acceptance,

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[98] Although that does not mean that the subject would not use this language to describe themselves.

[99] The narratives that I discuss throughout this section are problematic only at the population level. An individual may find strong identification with any or all of these narratives. The issues that I discuss here only arise when these narratives are applied to all trans people as a blanket explanation of our experience and identity.

it also creates its own problem. The medicalized model of transness relies on this narrative in diagnosing gender dysphoria and "treating" trans patients with hormone therapy and surgery, and:

> "while most theorists appreciate that the medical system's recognition of gender variance has its benefits (e.g., access to safe treatments and surgeries, insurance coverage), they also acknowledge the ways in which this system reifies a dyadic and rigid view of gender and denigrates bodies that cannot be neatly organized into one of the two conventional gender categories: masculine male and feminine female" (Johnson and Repta, 2012, pg. 33).

So this 'wrong body' narrative still conflates sex and gender despite claiming to separate them. It allows for an understanding of gender that is not determined by sex, however it says that there is a certain body that is male and a certain body that is female and trans people will aspire to one of those bodies based on their gender identity. This turns the "sex determines gender" narrative on its head because here gender determines sex as trans people are seen to be aligning their bodies with their gender. One of the problems with this model is that it changes the direction of influence from sex determining gender to gender determining sex without doing anything to challenge the status quo of those linked binaries. While I do hold that gender can influence sex, understanding gender as the sole and direct determiner of sex is overly simplistic and any model of sex and gender that only allows for two equated binaries (man and a "male body" on one end and woman and a "female body" on the other), regardless of the direction of influence, is woefully incomplete.

Beyond the Binary

Non-binary people inherently disrupt the 'wrong body' narrative. If there is no conception of an ideal non-binary body, then how are non-binary people "trapped" in their current body and what type of body are they supposed to be aspiring to[100]? There

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[100] This does not mean that non-binary people never endeavor to change their bodies and never experience a 'wrong body' narrative, indeed many do. The disruption comes instead from the fact that if they do want/need to change their bodies, there is not a culturally legible ideal non-binary body for them to move toward. The 'wrong body' narrative, as Bettcher explains, depicts trans women moving toward an ideal female body and trans men moving toward an ideal male body. Of course many trans women and trans men will also individually challenge this narrative by choosing to forgo hormones, certain surgeries, etc.

can be no ‘wrong body’ narrative without the accompanying ‘right body’. As a non-binary trans person, I don’t view my body as a barrier of any kind, nor as a prison I am trapped in, and I have no desire to change its external appearance at present[101]. I am not trapped in my body, if I am trapped in anything it is in a world that doesn’t make room for me. In addition I wholly reject any notion that being trans means I have to hate my body[102]. In their work with transmasculine people in Australia, J.R. Latham identifies four axioms that typify the way medical texts and even seemingly supportive medical care providers conceive of transness. They are that “1) transexuality is a disjuncture between mind and body; 2) transexuality is hating having the wrong genitals; 3) transexuality is painful and debilitating; and 4) transexuality is resolvable with surgical and hormonal body modifications” (Latham, 2016, pg. 30). These ideas, that trans people have a disconnect between their psychological gender and their physical body, which leads them to hate that body causing them extreme distress that can only be relieved by medical intervention bringing the mind and body back into alignment, are the institutional codification of the “wrong body” narrative. It is this model that defines trans people in relation to the necessary hatred of their bodies that many trans people are resisting.

It is perfectly reasonable for a trans person to feel uncomfortable in their body and/or wish to change it, but change is certainly not necessary and it is not what defines us as being trans. I do not see my body as female despite the ‘F’ marker that appears on my birth certificate. My experience inside this body is as a transmasculine non-binary person and this body that has carried me through that lived experience is also masculine and non-binary regardless of any of its individual features. I, like most people, could not even identify most of those features with any degree of certainty. I have never had my chromosomes tested, I have never seen my internal reproductive system, and I don’t need to. It would not change my gendered experience of inhabiting a body to know that said body had XX chromosomes or ovaries or fallopian tubes. As

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[101] Important work challenging the idea that having a body that differs from expected norms means one must desire to “fix” or change their body through medical intervention can be found in intersex (Chase, 1998; Karkazis, 2008), disability (McRuer, 2006; Overboe, 2009; Davis, 2016), and fat (Murray, 2008; Lupton, 2013; Burford and Orchard, 2014) scholarship.

[102] Of course some trans people do hate or have an otherwise complicated relationship to their body and this is not to dismiss that but rather to open up possibilities beyond that experience.

the inhabitant of this body I am the sole expert on its state and status and this is not a female body. My existence and the existence of so many other people who do not fit into strict sex and/or gender binaries completely invalidates the “wrong-body” narrative and questions whether or not there could even ever be a single perfect narrative to understand transness.

Spanish philosopher Paul B. Preciado frames a compelling “beyond the binary” narrative in their book *Testo Junkie*. They relay a lot of experiences that will be familiar to many trans people (such as childhood gender policing and the complex feelings surrounding taking hormones), but in explaining their relationship to gender they reject both binary options presented to them, stating:

> “I do not want the the female gender that has been assigned to me at birth. Neither do I want the male gender that transsexual medicine can furnish and that the state will award me if I behave in the right way. I don’t want any of it” (2013, pg.138).

They are not entirely refusing a masculine gender but rather the specifically male gender that is mediated by medical bureaucracies and state-controlled technologies which are accessible only on the basis of performing appropriate masculinity. Furthermore, they describe the reason for their taking testosterone as one of disruption rather than transition:

> “It’s not a matter of going from woman to man, from man to woman, but of contaminating the molecular bases of the production of sexual difference, with the understanding that these two states of being, male and female, exist only as ‘political fictions,’ as somatic effects of the technical process of normalization.” (pg. 142)

Here Preciado takes on not just the gender binary but also the (related) sex binary. They identify sex as socially constructed, later elaborating:

> “There are not two sexes, but a multiplicity of genetic, hormonal, chromosomal, genital, sexual, and sensual configurations. There is no empirical truth to male or female gender beyond an assemblage of normative cultural fictions” (2013, pg. 263)

I go into this idea in greater detail later in this chapter but this understanding of the diversity of various sexual characteristics and the way they are socially defined and redefined (or refuse to be defined) is the most valuable insight provided by the “beyond the binary” narrative.

While this “beyond the binary” narrative fits better with my experience and that of some other trans people, applying it too broadly would be a mistake. When eschewing the wrong-body model Bettcher highlights that this “beyond the binary” narrative is the only alternative model of transness that is widely discussed. This model claims “that because transgender people don’t fit neatly into the two dichotomous categories of man and woman, attempts are made to force them into this binary system” and that trans people are simply people who don’t fit into a binary gender system (Bettcher, 2014, pg. 384). The “beyond the binary” model, while not as widely accepted and therefore perhaps not as pressing to dismantle as the “wrong body” model, is still incomplete and over simplistic. Some people do identify as binary men or as binary women (whether they are cisgender or transgender) so as an overarching model it disregards the validity of self-identification which is so crucial to trans people. If it is conceded that trans people can identify as male or female then this model would imply that, since trans people are supposedly outside the binary gender system, that trans woman is a different gender category than cis woman and the same for the categories of trans and cis man. In fact, I assert that they are the same gender category just with a different gender history: trans women are women, the “trans” is just an optional layer of specification. Therefore, any discussion of breaking gender binaries can only be applied to people who identify as breaking those binaries and can not be a broad sweeping central narrative. Furthermore neither the “wrong body” model nor the “beyond the binary” model offers security or certainty of validity for trans people’s claims to their gender. As an alternative Bettcher offers the view that rather than opposing gender binaries (or being trapped in the wrong body), trans people challenge the perceived reality of a relationship between gender presentation and genitals. The gendered terms of “man” and “woman”, “male” and “female” have multiple and flexible meanings, perhaps even an infinite number of meanings for each individual who experiences "maleness" and "femaleness", "manhood" and "womanhood". As Judith Butler notes, this is not simply because people who break gendered norms exist but rather because stable definitions of gender do not exist:

> "If one 'is' a woman, that is surely not all one is; the term fails to be exhaustive, not because a pregendered 'person' transcends the specific paraphernalia of its gender, but because gender is not always constituted coherently or consistently in different historical contexts, and because gender intersects with racial, class, ethnic, sexual, and regional modalities of discursively constituted identities" (1990, pg. 4)

Therefore, binary trans people are not breaking the categories of male and female but are rather redefining and expanding what those categories mean, and non-binary trans people are adding a category, or rather many categories, to the list.

Harmful Narratives

Not all narratives of transness that need to be challenged are coming from a place of attempted inclusion. Indeed, some of these narratives are used in a directly antagonistic way to invalidate trans people. Anti-trans and specifically trans-misogynistic[103] rhetoric uses this idea of gendered bodies to talk about "men dressed as women", specifically in reference to using public bathrooms. It centers around creating an idea that trans women are actually men because they have "male bodies", that as men (or at least as possible possessors of a penis) they are a threat to women, and therefore they cannot be allowed in women's public bathrooms. This belies socio-cultural and media obsessions and fascinations with trans women's bodies and in particular with their genitals. Their bodies are sexualized in so called "she-male" pornography, and are used for comedic effect in more mainstream media (a classic example being The Hangover Part II, 2011[104]). The flawed logic at the root of this

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[103] Trans-misogyny is the specific form of discrimination transfeminine people face as a result of their being trans and women, femme presenting, and/or aligned with femininity in some way (see Serano, 2016).

[104] The scene in question involves one of the lead characters learning that the previous night he drunkenly had sex with a woman who works in a club. She is standing facing away from the camera naked from the waist down and dramatically turns around to reveal her penis, to the shock and disgust of the three men and for the apparent amusement of the audience.

"humor", exoticism, sexualization, and virulent rhetoric, the notion that trans women are really men, is incredibly dangerous and leads to violence against trans women as I discussed in Chapter 2. As American trans activist Janet Mock explains in her memoir "Redefining Realness: My Path to Womanhood, Identity, Love & So Much More",

> "My assignment at birth is only one facet of my identity…acknowledging this fact and how it has shaped my understanding of self has given me the power to challenge the ways in which we judge, discriminate, and stigmatize women based on bodily differences. The media's insatiable appetite for transsexual women's bodies contributes to the systematic othering of trans women as modern-day freak shows, portrayals that validate and feed society's dismissal and dehumanization of trans women." (2014 pg. 255)

Her experience is that trans women are simply women who may inhabit different bodies but that the obsession with those different bodies is ultimately harmful.

In their Slate article *What is a "Male Body"*, American lawyer and trans activist Chase Strangio argues that trans activists and allies who rely on the "wrong body" narrative to explain transness in ways cis people will understand are actually failing trans people in the long run. Trans advocacy needs to focus on the fact that trans men are just men and trans women are just women (and that non-binary people are just non-binary people and furthermore that non-binary people exist), or as Strangio puts it, "when a transgender woman uses a women's restroom there are still zero men—biological or otherwise—in that restroom" (2016). This challenges the deceitful trans person narrative as well by saying that trans women are not trying to hide their "male-body", but rather that they indeed have a female body regardless of its appearance. Many trans people assert that there is no point at which they "become their gender", they have simply always been their gender; a trans woman does not become a woman when she comes out, starts hormone therapy, or has surgery, but she has always been a woman.

Sex and Gender Attribution

The biggest issue with the idea of male-bodiedness and female-bodiedness then is the question of what makes a biological man or a biological woman in the first place.

This sex binary erases intersex people the same way the gender binary erases many trans people so it is already invalid as a dichotomy. If we take the binary aspect out of the equation and look at male-bodied and female-bodied as merely two possible types of bodies out of many, there is still a definitional issue. No two bodies are exactly alike[105] so even with humans allegedly being sexually dimorphic, all male bodies are not alike and neither are all female bodies. This understanding challenges a simple model of human sexual dimorphism.

> "Biologists and medical scientists recognize, of course, that absolute dimorphism is a Platonic ideal not actually achieved in the natural world. Nonetheless, the normative nature of medical science uses as an assumption, the proposition that for each sex there is a single, correct developmental pathway." (Blackless et al., 2000, pg. 151).

The embracing of this impossible ideal of absolute sexual dimorphism is what provides existing definitions of these types of bodies:

> "most consider that at the level of chromosomes, hormones, and genitals, dimorphism is absolute and, by implication, such traits are discrete rather than quantitative…however, developmental biology suggests that a belief in absolute sexual dimorphism is wrong." (Blackless et al., 2000, pg. 163).

If a holistic definition of male-bodiedness and female-bodiedness is insufficient, then the body would have to be broken down into components and those components labelled as male or female. Then the question becomes how many "male" or "female" components does a body need to have to be labeled one way or the other? How is a body with breasts and a penis labelled? How about a body with no breasts, facial hair, a penis, a uterus, and ovaries? These hypothetical bodies need not belong to trans people but trans people certainly problematize the idea of male and female bodies. What makes a penis, a lack of breasts, testicles, facial hair, etc. male and breasts, the lack of a penis, lack of facial hair, a uterus, vagina, ovaries, etc. female in the first place? If it is about perceived reproductive capabilities then is a woman only female from age 12-50 and a few days a month? Do we keep our gender after we die? (Kessler

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[105] Perhaps barring identical twins but that's beside the point.

and McKenna, 1978/2006). Which sex characteristics are prioritized in determining gender over others? The only quality used to medically label bodies in the immediate moment after birth is the external appearance of genitalia, so that factor is definitely privileged, but is it all about genitalia? What about chromosomes? The same body using different criteria could be identified as male-bodied, female-bodied, or somewhere in between.

In their 1978 article *Toward a Theory of Gender*, psychologists Suzanne Kessler and Wendy McKenna asked participants to identify whether people were male or female when given different information across two separate studies. In the first study the researchers had participants ask ten “yes” or “no” questions and then decide after each question whether the person they were asking about was male or female. The participants were unaware, however, that the answers to their questions were predetermined random “yesses” and “nos”. The answers did not correlate with any actual person and this led to many gendered “inconsistencies”. The participants explained these away, such as rationalizing that some women are very tall and that some men have protruding breasts. Only 25% of people asked about the person’s genitals straight away:

> “when asked after the game why they did not ask about genitals, players explained that it would have been tantamount to asking ‘Is this person a male (or female)?’, which was an unacceptable question since finding the answer was the object of the game” (Kessler and McKenna, 1978/2006, pg. 167)

Of those who did ask about genitals, some refused to continue with the rest of the ten questions, believing that they had an unequivocal answer. From this Kessler and McKenna concluded that in gender attribution, physical and biological characteristics are more important than other social information and once someone has decided on a gender attribution they can filter all other information to fit into that. In other words, to participants, gender equalled genitals. The most ubiquitous real-life example of this is doctors proclaiming “it’s a boy” or “it’s a girl” purely based on genital appearance either after birth or even sooner in an ultrasound.

The second study Kessler and McKenna conducted used transparent overlays, each with a different physical characteristic that could be combined to create a sketch of a whole person. There were eleven overlays[106] to create ninety-six total possible combinations and each combination was shown to five men and five women for a total of 960 participants. Each participant was asked if the figure was male or female, how confident they were, and how they would change the figure to make it the "other" gender. From this study they found that participants were more likely to label figures as male. In a female context the feminine characteristics were seen as feminine but in the male context the feminine characteristics were ignored or seen as masculine: "the only sign of femaleness is an *absence of male cues*" (Kessler and McKenna, 1978/2006, pg. 171). Genitals were the most important signifier and once gender attribution was made on the basis of genitals all other characteristics could be explained away. However, penises were more likely to result in a male identification, regardless of other characteristics, than a vulva was to result in a female identification. Participants were also most confident with their gender attribution when the image included a penis. When asked what they would change about the image to change its gender attribution, many said they would remove the penis but very few said they would add a vulva, and conversely a similar number said they would add a penis but very few said they would remove the vulva. So not only does gender equal genitals, but "gender attribution is, for the most part, genital attribution; and genital attribution is essentially penis attribution" (Kessler and McKenna, 1978/2006, pg. 173).

Gender attribution, they found, is not a process that happens anew with each encounter, but is rather a strong first impression.

> "Almost nothing can discredit a gender attribution once it is made. Even the loss of the original criteria used to make the attribution might well become irrelevant. The man might shave his beard; the woman might have a mastectomy. The gender attribution will not change, though, merely because these signs no longer exist" (Kessler and McKenna, 1978/2006, pg. 177).

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[106] These characteristics were "long hair, short hair, wide hips, narrow hips, breasts, flat chest, body hair, penis, vulva, 'unisex' shirt, and 'unisex' pants" (Kessler and McKenna, 1978/2006, pg. 168).

This can make things difficult for trans people when interacting with people who knew them before they were out or who know they are trans. These binary, dichotomous, and distinct gender attributions persist despite people understanding that the reality of gender expression is far more diverse. For example, as Kessler and McKenna explain above, people can conceive of a woman without breasts (who has had a mastectomy), although the presence of breasts is still most likely to result in a female gender attribution.

> “Our reality is constructed in such a way that biology is seen as the ultimate truth…Scientific knowledge does not inform the answer to ‘What makes a person either a man or a woman?’ Rather it justifies (and appears to give grounds for) the already existing knowledge that a person is either a woman or a man and that there is no problem in differentiating between the two.” (Kessler and McKenna, 1978/2006, pg.178-179)

Kessler and McKenna explain that previous models that seek to do away with gender dichotomies ignore the strength of the physical dichotomies they are derived from and rely upon. In order to truly allow for the full diversity of gendered experience I will argue that gender needs to be revealed as a social construction in all of its forms, including the physical.

Sex and Gender Attribution in Healthcare

The gender attribution paradigm explained above can be seen in a variety of ways when trans people interact with a cisnormative[107] healthcare system. Ben, a transmasculine person, told me about his experience getting his Pre-T blood test[108] results:

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[107] Cisnormativity is the assumption that everyone is cisgender. For example, a doctor automatically referring a woman for cervical screening and not referring a man is cisnormative because assuming that all women and only women have cervixes ignores the transfeminine people who do not need such services and the transmasculine people who do. It is used to typify the healthcare system here because as a transmasculine person Ben was an unexpected variance that the care providers could not make sense of.

[108] Before beginning testosterone, trans men and other trans people undergoing this type of hormone therapy are given a blood test to check existing testosterone levels, liver functioning, and general health.

> “But it was, it was really funny actually… I went to get the test done, I did actually manage to get the bloods out of me and into the system whatever it is but after that point the people just got really really confused. They were just like ‘uh I don't know what to do’…I called them to ask for my results and because my voice wasn’t, I sound like a female basically, they just were so confused and they asked me all sorts of really bizarre questions. They asked me…if I had erectile dysfunction because something to do with the testosterone levels…I was like ‘no I just need my blood results’ and they…they were really confused and they were, I think they thought I was a cis male with some kind of hormonal problem and also erectile dysfunction…who needed their bloods tested and then when they gave me the results they told me that I should come in straight away because I was very low on testosterone”

The medical professionals in this interaction were assuming Ben was cis. When they were confused by his high pitched voice they assumed he was a cis woman and when they thought his low testosterone was concerning and potentially causing erectile dysfunction they assumed he was a cis man. Despite the fact that, barring a hormonal issue, all humans produce testosterone, they assumed someone getting their testosterone levels tested had to be male, and they further assumed that as a male he would have a penis, that that penis would and should be capable of an erection, and that he should have testosterone levels within a certain range. This series of assumptions, all based in cisnormativity, shows a lack of education and/or understanding on the part of these medical professionals in regards to the trans patients they are treating. This is not an isolated occurrence as another participant, Adam, was even advised during his GIC appointment to make certain that he reiterated to the people taking his bloods that they needed to check testosterone levels because many of the clinic’s other patients had had an issue with the people testing the bloods seeing an “f” marker in the system and ignoring the request to test testosterone levels, perhaps assuming it to be a mistake. Assumptions around gendered bodies are so strong that rather than running all of the tests requested on the form as is standard practice, and testing testosterone levels even if it was a mistake on the form and would do no harm, lab technicians decide not to test the testosterone levels of someone they assume is female.

In the same way that gendered stereotypes obscure scientific knowledge when discussing gametes, as discussed in Emily Martin’s work above, these socio-cultural assumptions block healthcare providers from giving the best care to their trans patients. Instead of traditional gender roles the stereotypes they are relying on are false certainties such as “all men have penises”, “women don’t need their testosterone levels tested”, and even “an ‘f’ marker in their file means the patient is a woman”. Hopefully this critique will shine a light on the problematic nature of these ingrained assumptions around the relationship between gender and bodies in healthcare just as Martin did in the realm of science writing. The situations described above would not have been possible if the healthcare providers were not operating inside a powerful cisnormative paradigm. If these providers could imagine that their patients might be trans, then they would have no reason to question someone with an “f” marker on their records getting their testosterone levels tested. This clearly shows a disconnect between what is expected of gendered bodies and the reality of bodies, a formidable barrier that trans people face while seeking healthcare and in their everyday lives.

Biological Essentialism

Anti-trans rhetoric relies heavily on the idea that there are certain biological truths that cannot be altered, that the reality of being born in a male or female body is absolute. Some so-called TERFs[109] focus on chromosomes, like Janice Raymond condemning trans women in feminist spaces when they say, “women take on the self-definition of feminist and/or lesbian because that definition truly proceeds from not only the chromosomal fact of being born XX, but also from the whole history of what being born with those chromosomes means in this society” (1979/2006). Others focus on genitals, such as in Psychopathia Transexualis in which David Cauldwell concludes that the subject who identifies as male is in fact female, observing that “her menses were regular and normal…her external genitals were of perfect feminine formation, the clitoris normal…hair distribution and voice normal” (1949/2006). Yet others invoke a combination of the two, such as Germaine Greer discussing intersex people by stating “she was not a woman but a failed male who may pass for a female…AIS[110] ‘females’

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[109] “TERF” stands for Trans-Exclusionary Radical Feminist, a rhetoric which is widely disregarded by feminist scholarship and activism.

[110] Androgen insensitivity syndrome.

have no female organs and not a female cell in their bodies" (Greer, 2007, pg. 88). The issue with all of these approaches to labeling sex is biological essentialism. "Instead of taking responsibility for who counts socially as a man or woman, people turn to science, trying to use the biological criteria for male to define a man and the biological criteria for female to define a woman" (Roughgarden, 2004/2013, pg. 148).

Even scholars who tout the importance of bodies in the gender discussion allow for a level of fluidity and social constructedness. Australian philosopher Elizabeth Grosz, for example, recognizes that culture inscribes our bodies "permanently and impermeably" in specifically gendered ways (1994, pg. 141). As a feminist scholar Grosz continually challenges the "naturalness" attributed to bodies; "[t]here is no 'natural' norm; there are only cultural forms of body, which do or do not conform to social norms." (1994, pg. 143). Biological essentialists on the other hand are refusing to engage in a nuanced definitional process and are resorting to biology to define femininity (feminine and female genders are overwhelmingly the target of this rhetoric). As Judith Butler says, "the return to Biology as the ground of a specific feminine sexuality or meaning seems to defeat the feminist premise that biology is not destiny" (1990, pg. 41). This essentialism is not theoretically rigorous and ultimately is anti-feminist in the way it insists on linking and limiting "womanhood" (and it is mostly womanhood as trans women are the overwhelming target of this rhetoric) to one specific biological destiny.

Attributing Sex

Sex, nearly always cast as the ever constant variable in this saga of gender diversity, is in reality quite diverse itself. As explained above, intersex people are people who are born with ambiguous or a mixture of sexual characteristics, people who are not explicitly male-bodied or female-bodied. To return to and expand upon the question posed in the previous section, what makes a male body, a female body, or a non-binary body, there must be a set of criteria that defines different sexes or different types of bodies, and for these classifications to exist and then to be imposed upon people definitional criteria must be clear and in the case of multiple criteria there must be a classification hierarchy[111]. Currently, genitals are favored in this hierarchy: “in order to say that a transsexual (after genital reconstruction surgery) has undergone a ‘sex change,’ we must discount other features, including chromosomes, and select genitalia as definitive” (Bettcher, 2014, pg. 386). The importance of genitals in determining someone’s “true” sex is also central to the trans panic defense discussed in Chapter 2. Preciado discusses enjoying the openness of genital possibilities that exists prior to revealing, and thus committing to, a singular genital appearance within a sexual encounter:

> “I take turns imagining myself with and without a cock, and the two images keep following each other like a game on a seesaw. But I know that the moment I get undressed, she'll see only one of these bodies. Being reduced to one fixed image frightens me. I keep my clothes on a few minutes more, so I can enjoy the double option little longer.” (2013, pg. 88)

Similarly, Adam recalls the differing experiences of his genitals being hidden versus being visible/known in these two stories from his childhood:

> “And so if I was being very headstrong that day and going ‘no I wanna wear the boy’s bathing suit, I wanna wear this bathing suit’…cause I don’t think I ever called it the boys bathing suit I was just like ‘this is the one I wanna wear’, she just didn’t argue she was like ‘yeah whatever’ and then I’d sort of go running around this wading pool with like just shorts on and you know everybody assumed I was just a boy with long hair because from you know hiding the sort of area of genitals there was no hugely defining difference. And I should point out that when my brother was born there was like a moment where my mom had us both in the bath and I said you know ‘when, when’s my penis gonna grow?’ and she said ‘no…it’s not gonna happen’, and I, I was probably four and…I sort of went ‘okay’, but inside my brain I was like ‘oh you’ll see’, like this four year old thinking she’s wrong”

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[111] For example if two of the criteria for a male body would be the presence of a penis and the absence of breasts, one of these two criteria would need to be valued higher than the other to account for bodies where these two states do not exist in tandem. If the presence of a penis was placed above the absence of breasts then, for example, a trans man with no breasts but no penis would not be labelled as having a male body but if the absence of breasts were placed atop the hierarchy than they would be labeled as having a male body.

In Adam's experience his genitals were the only thing that may have prevented him from passing as a boy as a child and they are something he remembers wanting to change from a very young age.

Genitals are clearly a key player in labeling bodies but there is a lot of diversity to be found where they are concerned. For example, the four genitals shown below, all of which would likely be labelled "male" and "penises", vary greatly. With genitals, as with other characteristics it is not obvious what the "rule" is because as American evolutionary biologist Joan Roughgarden notes, "when it comes to humans, the biological criteria for male and female don't coincide 100 percent with present-day social criteria for man and woman" (2004/2013 pg. 148). Even though Adam desires to one day have metoidioplasty[112] which will give him a penis by many if not all definitions, is he not still currently male and does this male identity apply to his body as well? At what point does his or anyone else's body become a male body? If it is when they obtain a penis, what defines a penis? Is it only a clitoris that has diverged developmentally to form a penis in utero meaning trans men never have male bodies? Is it the result of any genital surgery? Is the very different result of metoidioplasty as opposed to phalloplasty to be counted? Is it the enlarged clitoris (or what is often called a clitoris[113]) resultant from testosterone therapy? If not, then why is a clitoris that develops into a penis in utero valued over a clitoris that develops into a penis later in life through hormone therapy and/or surgery? Or is a penis merely whatever the possessor of the penis decides it to be?

While important, genitals are not typically used in gendering bodies in interpersonal interactions on a day to day basis, simply because they are not often visible. That is where secondary sex characteristics[114] move to the forefront. As Preciado notes, "the beard and the voice, and not the penis and the vagina or X and Y

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[112] Metoidioplasty is a surgical procedure where what is referred to as the clitoris (which will become larger from taking testosterone) is made into what is referred to as a penis by detaching it from the labia minora. It is a simpler alternative to phalloplasty that does not require a skin graft, so it therefore results in a smaller penis. It is often accompanied by a scrotoplasty where the labia majora are formed into what is referred to as a scrotum with the use of silicon implants.

[113] Trans people sometimes use different words to refer to their body parts, particularly those that carry heavily gendered connotations such as "clitoris" or "penis".

[114] All sexually dimorphic features that are not part of the reproductive system.

chromosomes, are the dominant cultural public signifiers of gender in our society" (2013, pg. 227). Speaking voice is particularly interesting as it is not a visible feature, but "male bodies" are still supposed to produce a low pitched voice and "female bodies" a high pitched voice, related to the size of the voice box and the length of the vocal chords which are understood to be sexually dimorphic characteristics. Even for cis people there is a massive range of what "high pitched" and "low pitched" can mean as well as overlaps in the center where cis men with higher voices and cis women with lower voices may reach the same pitch or even pass each other towards the other side of the vocal spectrum. However, a trans person who "passes" visually or whose gender is being questioned by others may still be outed by their speaking voice so this inexact criteria is a point of concern. Adam talked about "constantly worrying…wondering if the shopkeeper is gonna think my voice is low enough for a man or if he's gonna misgender me". This is concerning because if trans people like Adam are "constantly worrying" about being misgendered in public they may withdraw somewhat from public life. That kind of social isolation leads to poor health and mental health outcomes (see Trout, 1980; Cacioppo and Hawkley, 2003; Tomaka et al., 2006; Hall-Lande et al., 2007; Cornwell and Waite, 2009; and Cacioppo and Hawkley, 2009). In addition to being socially isolating, being misgendered can have a dissociating effect. When I know someone is talking about me from social or context clues but they use female pronouns or terminology it feels as though they are talking about someone else and that dissonance is distressing. Another participant, Ben, said "the worst part is when if they gender you correctly and then you open your mouth and you speak and then they apologize"[115]. Some trans people go through voice training to learn to raise or lower their pitch and there are surgical options available to adjust the size of the voice box and length of the vocal chords to achieve a more "masculine" or "feminine" voice. Still others come up with their own solutions to this problem, like Ben.

> "when I was pre-testosterone, I'm partially deaf but I'm not fully deaf…so I have like a lot of deaf friends and everything so I would often pretend I was fully deaf so that I wouldn't have to use my voice so that I could pass easier"

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[115] I too have experienced the frustrating exchange of "how can I help you sir?" "I was just wondering…" "oh ma'am I mean ma'am oh I'm so sorry".

He was able to use sign language to avoid being outed by his higher pitched voice, an eminently creative adaptation. Although cis men have vocal pitches within a wide range, Ben was worried that his higher pitched voice would out him. In this instance his voice (over physical characteristics) was something he could control by opting to not speak so he did so in order to pass, the same way people will use clothing, makeup, hair style, etc. Genitals and voice are just two examples but any characteristic that is supposed to be able to identify the sex of a human body is going to be complicated by (and complicate the lives of) trans people.

The disconnect between biological and cultural definitions is the cause of much confusion and debate. When biologists are sexing bodies, or any organism, it comes back to the sperm and the egg. It is important to note that I am merely relaying one discourse around sex that is used in biology here. As I will go on to explain I am not endorsing this discourse nor its application to human bodies. To do so would be tantamount to biological essentialism, which as I discussed earlier must be avoided. In this biological discourse, a male of a species makes small gametes (called sperm) and a female of a species makes large gametes (called eggs). This may seem like an oversimplification but in this case the binary system works fairly well as species with more (or less) than two gamete sizes are extremely uncommon, although not nonexistent. However, there is still allowance for an exciting amount of diversity within this classification system. There are instances in different species of animals and plants of females changing to males, males changing to females, changing back and forth between male and female, and the states of maleness and femaleness existing concurrently. “These examples of sequential, simultaneous, and crisscrossing hermaphrodism show that male and female functions don’t need to be packaged into lifelong distinct bodies” (Roughgarden, 2004/2013, pg. 154). Furthermore sex itself refers to the mode of reproduction which humans and many other species employ which involves two parties and the mixing of genes. With this in mind it makes sense that sex classification is based on gamete size, but then is there any usefulness in using sex as a classification system at all beyond discussions of reproduction? As Roughgarden notes it is extremely limited in what it tells us and is insufficient to describe humans and our vast and diverse social classifications. While I feel I would be remiss in not addressing human biological diversity it is not the existence of such diversity that validates trans identity. Just as biological essentialism that presumes binary sex is a poor way of modeling gender so too is any model that relies on a definitive, causal relationship between biology and gender. I merely hope to point out that it is not only the binary gender model[116] that is incorrect but also the binary sex model, and that the two models are linked.

Postgenderism

One approach to the dismantling of sex and gender binaries is postgenderism or a movement toward the elimination of gender through social change and advances in biotechnology. Inspiration can be drawn from societies that have already broken the gender binary or have perhaps never had it,[117] however a truly post gender society would be a completely new phenomena. The existence of trans people, which inherently challenges binary gender and sex categories, can be used as an example of a movement toward postgenderism:

> “today’s transgender movement is a roiling, radical critique of the limits of gender roles, with folks living in totally new categories, such as non-op transsexual, TG butch, femme queen, cross-dresser, third gender, drag king or queen and transboi. These genderqueer activists and theorists advocate postgender attitudes, such as promoting the use of gender-neutral pronouns such as ‘ze', ‘per’, and ‘zir,’ or the terms pansexual or omnisexual instead of the binary ‘bisexual’” (Dvorsky and Hughes, 2008, pg. 7).

For many of these people who don’t fit into the gender binary simply living as themselves is a revolutionary act. However “while transgendered[118] bodies can call our

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[116] Note that it is the binary gender <u>model</u> and the binary sex <u>model</u> that I am challenging here. The problem is with a model that only allows for two genders and/or two sexes. The problem is not with any individual who identifies their sex and/or gender within one of these binaries.

[117] There are cultural labels for some non-binary genders such as ‘hijra’ in India or Native ‘Two-Spirit’ people in North America but simply having a more widely accepted label has not stopped these groups from facing stigma and merely breaking the gender binary is a long way from postgenderism.

[118] Although many theorists have used the term “transgendered” it is slightly outdated and I will not use it here as it implies that transness is something that happens to someone whereas the term “transgender” is a more neutral descriptor of someone’s state of being.

categories of sex and gender into question, they can also confirm and reinforce the conventional gender system in the way that transgendered bodies are judged and evaluated for sex reassignment surgery” which is distinctly not postgenderist (Johnson and Repta, 2012, pg. 33). Some trans people are very comfortable within binary gender categories and others may portray that they are in order to access transition related healthcare.

While many trans people do fit into traditionally binary gender roles and expressions (although many also do not), it is the concept of transness that supports many of these postgenderist ideas. Those who do fit into that mold may feel social pressure to conform to a certain gender role to access healthcare, to feel secure, etc or they may simply feel most comfortable in a traditionally masculine or feminine gender expression. Within medical spaces, trans people often feel they have to alter, slightly or drastically, the ways in which they present themselves in the context of the GIC in order to be approved for the hormones and/or surgery they are seeking. As Dean Spade notes in their piece “Mutilating Gender”:

> “The self-determination of trans people in crafting our gender expression is compromised by the rigidity of the diagnostic and treatment criteria…To adopt the medical understanding of transsexuality is to agree that SRS is the unfortunate treatment of an unfortunate condition, to accept that gender norm adherence is fortunate and healthy, and to undermine the threat to a dichotomous gender system which trans experience can pose. The reification of the violence of compulsory gender norm adherence, and the submission of trans bodies to a norm-producing medical discipline, is too high a price for a small hope of conditional tolerance” (2000/2006, pg. 329)

This harmful phenomenon of gender norm adherence that Spade describes conceals layers of identity and diversity. For example Ben identifies as transmasculine and has said he is more male than not but “if there's some other option I usually tick that unless I feel like the place that I'm you know at is gonna discriminate against me and then I will always tick “M", or "F" depending on where I am”. The finer details of his identity are being erased in these instances. This becomes especially relevant when, as Johnson and Repta note, trans bodies are being evaluated for transition related healthcare. Here

Ben describes his experience of obtaining his prescription for testosterone and feeling like he had to tailor his story to what they wanted to hear.

> “The, the vibe was the kind of thing it was expected I think although it wasn't really expressly said so I just went with that I-I just kind of gauged what they were doing and it seemed like when I was being assessed that's what they were looking for just ticking boxes, I think he was literally ticking boxes as I was going…so I just looked at that and I just thought okay I'm just gonna, you know cause I didn't go in there thinking I'm gonna lie through my teeth like I kind of just got in there and I thought ugh this environment is a little bit like intimidating I'm just gonna see how it goes and then that’s what it was that's what it ends up as I guess”

Ben’s experience shows how trans people being categorized by the healthcare system under traditionally gendered labels may largely be a case of confirmation bias, a self-fulfilling prophecy. To access HRT and certain surgeries, trans people ensure that they are ticking certain boxes such as expressing interest in a “complete” transition and monitoring their gender presentation when attending GIC appointments to come across suitably masculine or feminine[119]. This in turn validates the boxes and makes it appear as though this ordered view of gender is accurate. In reality, many people do not fit into these discrete categories. This would include all non-binary people including non-binary men and non-binary women as well as people who may identify their gender within the binary but break the norms associated with that gender in some way, such as a femme trans man. Not being able to tick those boxes authentically and showing the invalidity of constructed gender categories could be seen to support a postgenderist ideology.

The trouble here comes with radicalizing trans bodies as Bettcher points to in their critique of the “beyond the binary model”. Just as the medicalization of transness pathologizes trans people, so postgenderism politicizes them. An understanding of transness as something that is automatically radical and political is limiting and many trans people do not understand themselves that way. Adam demonstrated this when he explained how he just sees himself as a regular guy:

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[119] I go into how ticking boxes operates as a feature of the medical bureaucracy in chapter 5.

> “it’s just an easier way to help them sort of understand…if they, they wanna ask some questions I just say oh yeah I’m transgender, man, transgender male, but personally I just identify as a man cause I just I feel like you know there are ways in which I’ve never been great with labels, and trans is not something that I necessarily asked to be and that’s, I’m not saying there’s anything wrong with it, but just my own like personal gut feeling is that it’s another label that you know society has said well this is something you are to point you out as being different from the regular thing, the normal thing, and I don’t really see that much difference between me and and and cis guys”

Here Adam is rejecting the idea that there is anything inherently radical or even different about him. This sentiment was also echoed by another participant, Dan. To them, adding the qualifier of “transgender” separates them from other men and makes them feel other. Particularly because of the violence and harassment faced by trans people, normalizing sex and gender diversity is as crucial as ever. This does not mean doing away with the concept of gender altogether as proposed by postgenderists, but simply broadening the understanding of what gender is and can be, responding to an oppressive system not by rejecting it but by embracing, reclaiming, and reshaping it.

The Reintegration of Sex and Gender

As an alternative to postgenderism, I will propose a reintegration of sex and gender in our understanding of trans identity. The initial distinction between the two terms came as a response to “sex” and “gender” incorrectly being used interchangeably. In their 1995 article “Disaggregating Gender from Sex and Sexual Orientation: The Effeminate Man in the Law and Feminist Jurisprudence”, legal scholar Mary Anne C. Case argues passionately and thoroughly for a separation of the understandings of sex, gender, and sexual orientation. In this case it is in the context of United States law but many of their arguments have broader reaching applications. One of the multitude of examples cited as a reason to separate sex from gender is a situation where men were barred from serving on a jury in a paternity case. In this instance Justice Scalia argued, and Case agrees, that there was no gender[120] discrimination because feminine and masculine men were excluded equally but that there was sex discrimination (pg. 11).

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[120] In this article, Case uses the term gender to refer more to gender expression and degrees of masculinity and femininity then an individuals stated gender identity.

Case further explains that this separation is crucial for protecting things like Title IX[121] because as gender (expression) becomes more fluid the law must be able to distinguish to be able to protect, for example, masculine females from discrimination. Overall they conclude as follows:

> "In arguing that the treatment of the exceptional effeminate man teaches us much about that of both feminine and masculine women as well as masculine men, I hope to have shown how, once again, the margins can illuminate the center; and to have taken steps to make the world safe for us all, norms and exceptions, men and women, masculine and feminine, and every shade in between. By disaggregating gender from sex and sexual orientation focusing attention on the reasons why the feminine might have been devalued in both women and men, I hope to protect what is valuable about the traditionally feminine without essentializing it, limiting it to women, or limiting women to it" (pg. 105).

These aims are admirable and aspirational and were another necessary step toward fully understanding what gender is and the role it plays in society, however I argue that this need not be the final step.

The brief yet important separation of these two concepts has provided a key understanding that sex does not determine gender and that gender is self-identified. With that understanding these two aspects of identity can again be understood in tandem, the separation of sex and gender has served its purpose. For example, one of the key areas of focus in Case's article was employment discrimination. In this instance the first step was to show that certain "masculine" or "feminine" traits that made someone good for a certain job actually need not belong to men or women respectively because sex and gender are separate concepts. With that understanding however, I argue that the next step is to show that gender identity informs sex and sex can be part of that gender expression. I argue that sex identity is just as self-identified as gender, that a person has the type of body they say they have regardless of individual features. Any type of chest is masculine if the inhabitant of that body identifies as having a masculine body. What would usually be called a penis is feminine if the inhabitant of

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[121] Title IX is the federal statute in the United States banning sex discrimination in federally funded programs (U.S. Department of Education Office for Civil Rights, 2015).

that body identifies as having a feminine body. The sex of a body with any given combination of physical features cannot be identified by a third party observer the same way gender cannot be. This is not such a radical concept, it is a level of human diversity that is already prevalent in intersex people who are born into bodies that fall outside the sex binary, trans people who have sought transition related hormone therapy and surgeries, and in cis people who have had their bodies altered for other reasons, such as a cis woman who has had a double mastectomy as a result of breast cancer. This perspective of sex self identification and a link between gender identity and sex identity or gender identity and sex expression would allow for more sex diversity within the norm, specifically normalizing intersex and trans bodies.

Intra-acting Gender

In *Posthumanist Performativity: Toward an Understanding of How Matter Comes to Matter*, American feminist scholar Karen Barad discusses their theory of agential realism which challenges and expands upon previous models of materiality, addressing both how we understand matter epistemologically as well as how it is actually formed and altered ontologically. They also take the concept of performativity and elaborate and expand it to non-human bodies.

> “How might we understand not only how human bodily contours are constituted through psychic processes but how even the very atoms that make up the biological body come to matter and, more generally, how matter makes itself felt? It is difficult to imagine how psychic and socio-historical forces alone could account for the production of matter. Surely it is the case—even when the focus is restricted to the materiality of “human” bodies—that there are “natural,” not merely “social,” forces that matter. Indeed, there is a host of material-discursive forces— including ones that get labeled ‘social,’ ‘cultural,’ ‘psychic,’ ‘economic,’ ‘natural,’ ‘physical,’ ‘biological,’ ‘geopolitical,’ and ‘geological’— that may be important to particular (entangled) processes of materialization. If we follow disciplinary habits of tracing disciplinary-defined causes through to the corresponding disciplinary-defined effects, we will miss all the crucial intra-actions among these forces that fly in the face of any specific set of disciplinary concerns.” (2003, pg. 810)

This concept of intra-action directly opposes the term interaction. In an interaction there is an event between two pre-existing entities, the actors in the interaction exist and have an identity outside of the interaction itself. However intra-action asserts that the entity is itself the result of the event. The actors do not exist before or independent of the action. If you look at the gendered body through this lens there is no inherent, no innate physicality preordained by so called biological realities. Each gendered body is the product of a unique set of intra-actions. There is no before and after, the process of discovering one's gender reflects on one's body in the past, present, and future. For example a trans man coming to understand himself as a man also develops an understanding of what his male body is in his present (whether that is a body altered through hormones and/or surgeries or not), but that can also reflect back with him reunderstanding his past as having always embodied maleness even if he didn't realize it at the time and further projects into his imagining of his male future. Then if upon more realization he learns that perhaps he is a non-binary man, this too develops, reflects, and projects his understanding of himself as he continues to enact his gender, "matter is not a fixed essence; rather, matter is substance in its intra-active becoming—not a thing but a doing, a congealing of agency" (Barad, 2003, pg. 828). One of the ways he may enact this is through choosing a masculine name, using he/him pronouns, and generally using masculine language to refer to himself in the present and future but perhaps also in the past tense. He will ask others in his life to follow suit which will spawn a multitude of events where intra-action can take place. While not using this specific framework, geographer Tom Delph-Janiurek states in *Sex, Talk and Making Bodies in the Science Lab* that:

> "rather than simply being used to name or refer to gendered bodies, gendered forenames, pronounal referents and terms of address can be regarded as citational hailings that actually work to (re)produce gendered bodies in everyday interactions" (2001, pg. 40)

These everyday interactions are the points where intra-action takes place constantly (re)constructing the gendered body either in accordance with or against the gendered narrative of the individual.

This ongoing body project does not only intra-act with extra-corporeal entities but can incorporate them into the corporeal. In *Volatile Bodies: Toward a Corporeal Feminism* Elizabeth Grosz posits:

> “The body image is not an isolated image of the body but necessarily involves the relations between the body, the surrounding space, other objects and bodies, and the coordinates or axes of vertical and horizontal. The body image is the condition of the subject's access to spatiality (including the spatiality of the built environment).” (1994, pg. 85)

If we focus on the body image being reliant in part on the body’s relationship with other objects, then can those “objects” not become part of that body? I argue that it is not just the body image that is changed here but, in some cases, the body itself. When I previously discussed different types of penises I failed to mention a penis that to others may be understood as a packer[122], a strap-on[123], etc. which has been incorporated into the corporeal identity of the individual. It may be a removable, silicone penis but it is a penis nonetheless. Therefore a body without a penis is transformed into a body with a penis, even if only temporarily. Breast forms can be similarly incorporated. In these cases, the close identification with these objects change the body through these additions and/or extensions. The body is now one with a penis, breasts, etc. We can also understand disincorpor(eal)ating practices such as tucking[124] and binding[125] which remove something from the corporeal identity. This removal may not even require performing an action on the body but can happen entirely through narrative means. If the methods for (re)constructing bodies are opened up beyond the limited possibilities provided by medical interventions the corporeal possibilities are endless.

The physical characteristics however, the marks of “nature” that lead to a baby being assigned a sex at birth are not irrelevant because it is that act of assigning sex at birth that starts the chain of events of a gendered upbringing that results in transness

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[122] A packer is a prosthetic penis primarily used to create a bulge.

[123] A strap-on refers to a prosthetic penis specifically used for sexual play.

[124] Tucking refers to any method of concealing a penis and testicles.

[125] Binding is the practice of wearing a compression garment to flatten the chest.

existing in the first place. In *Putting the Body's Feet on the Ground: Towards a Sociological Reconceptualization of Gendered and Sexual Embodiment*, gender scholars Stevi Jackson and Sue Scott suggest:

> "that the gendered body is not always a sexual body, that the body can be sexual as both object and subject and that the connections between the gendered body and the sexual body require further exploration - we cannot reduce one to the other, but need to explore the relationship between them." (2001, pg. 16)

Gender does not supersede sex but neither can gender be subsumed under sex. What is important is unpacking and challenging the reality of those characteristics and the meanings attached to them as well as bringing to light hidden diversity. Barad says that "nature is neither a passive surface awaiting the mark of culture nor the end product of cultural performances" (2003, pg. 827). All of these forces are constantly intra-acting with each other in order to create material realities.

The Importance of Sex Self-Identification

But surely sex self-identification devalues trans people who want to "fully transition", those who seek to alter their physical body in order to completely align it with what is traditionally defined as a female body or a male body. If a trans woman was born in a female body, simply a different type of female body, and if she is therefore not "trapped" in a male body, then why should she ever want hormone therapy and surgeries? And if that is the case then why should the NHS provide these things to trans people? I argue that sex self-identification is crucial to good health and is therefore a right that everyone should have access to regardless of gender identity or experience. Opening up possibilities for sexed embodiment beyond strict, binary definitions does specifically uplift non-op trans people, people who seek a "partial"[126] and/or non-linear transition, intersex, and non-binary people. However binary trans people and/or people who seek a "complete", linear transition also benefit from this perspective. If sex is self identified in the sense that the inhabitant of a body has definitional power over that

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[126] Partial only in the eyes of the medicalized model of transness. A trans man who, for example goes on testosterone and never has any surgery would, if that's all they require, have undergone a complete transition.

body, then it also stands to reason that sex is self identified in the sense that the inhabitant of that body can also define what their body should look like and what features it should and shouldn't have. American sociologist James Hughes calls this "morphological self-determination" and in a response to a piece by pediatric endocrinologist Norman Spack hailing the medicalized model of transness explains their position as follows:

> "As the medical model of gender dysphoria is challenged by morphological liberationism on the one hand, and bioconservativism on the other, it will be difficult to make the case for covering the therapies with public or private insurance. But instead of reifying the medical model, transgender therapy should be used to challenge the illusory therapy/enhancement distinction, and establish that facilitating full self-expression is as legitimate a use of biotechnology as the fixing of diseases and disorders. There is little difference in the utility produced in someone's life from plastic surgery after an accident or burn, and plastic surgery to adjust a feature that has caused life-long dissatisfaction. There is no reason for insurance to discriminate against the latter in favor of the former. Why is breast reconstruction for the woman recovering from breast cancer surgery politically privileged over breast construction for the trans-woman? Neither are 'medically necessary' and both done to give psychological relief…Transgendered individuals are entitled to access to medical technology not because, as the advocates of the medical model such as Dr. Spack assert, they have a medical condition that demands correction, but because we should respect the right to morphological self-determination." (Hughes, 2006, pg. 11)

It is crucial that these two tenets, sex self-identification and a right to morphological self-determination, go hand in hand. This makes the most sense for a model that would try to understand the experiences of an incredibly diverse group of people as well as allow them access to life saving services. And they are life saving: trans people are far more likely to attempt suicide[127] than the general population and are at a greater risk for physical violence, drug and alcohol abuse, smoking, and other risk factors that negatively impact health (Grant et al., 2010). These increased risk factors are in addition to increased difficulty accessing healthcare, particularly mental healthcare. One

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[127] According to the National Transgender Discrimination Survey conducted in 2010 in the United States found that 41% of participants had attempted suicide compared to 1.6% of the general population. The Trans Mental Health Study, a smaller scale study conducted in the U.K. in 2012, found that 35% of participants had attempted suicide at least once and 25% more than once. They also found that suicidal ideation and attempts decreased after transition (McNeil et al.).

participant, Adam, was experiencing severe depression and anxiety[128] and initially had difficulty getting a referral for mental health services because he was already in the queue for a GIC and he was told that the psychologists at the clinic would help him. Once he convinced his healthcare providers that his mental health needs were beyond the scope of the gender clinic he ended up being referred for crisis mental health services through his London borough, but when he called to schedule the appointment he was consistently misgendered over the phone despite correcting the receptionist every time. This was extremely upsetting to him, particularly in his already fragile mental state. This exact lack of training on how to deal with trans patients puts yet another barrier between trans people and good physical and mental health. This is important and this theory is not stating that sex doesn't matter or treating the subject lightly in any way. It rather aims toward a model of sex and gender that fits with the reality of diverse bodies and respects an inhabitant of a body's own experience of being in that body, whether or not they see that body as currently incongruous with their gender identity.

The challenge with this reintegration perspective is that it is itself a challenge. It is a provocation to accepted norms surrounding sex and gender as well as to the dominant narratives as they are employed for greater trans acceptance. Difficult as it may be however, this perspective is more accurate in terms of the real life experiences of trans people and more inclusive than the "wrong-body" narrative, the "beyond the binary" narrative, or indeed then postgenderism. The theory allows for the inclusion of non-binary sex and gender identities, it centers the subject as the preeminent expert on their own body and self, and it celebrates rather then erases diverse human experiences of sex and gender. Strangio puts it beautifully when they say "I was assigned female at birth, but I have never had a female body. If it takes longer to convince the world of that than it would to simply say that I was born with a female body but am now male, I am invested in that longer path, because ultimately we will all be better off when we can challenge the idea that our body parts define us" (Strangio, 2016).

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[128] Which he explains were not related to his transness at all but stemmed from past trauma and childhood abuse.

Chapter 4: Medicalization

“my experience with gender and with chronic illness are quite, they parallel each other quite a lot I think” (Carey)

“Overwhelmingly, trans people’s requests for medical interventions catapult them into a paradigmatic trajectory that treats us all the same and systematically differently from other patients for the sole reason that we are trans.” (Latham, 2017, pg. 57)

“I at least have finally been convinced that living is injurious to health” (Zola, 1972, pg. 498)

In this chapter I highlight a formidable barrier to trans health: the medicalization of transness under the NHS as “gender identity disorder”. The problem with medicalization is two-fold. Firstly it stigmatizes transness which is a barrier to good mental health and secondly it creates medical gatekeepers and bureaucratic barriers[129] that delay or prevent trans people from accessing quality healthcare. To fully understand this problem I map transness using medical sociologist Peter Conrad’s framework of medicalization, expanding upon it throughout in order to unpack the ways medical social control is enacted on trans people. I conclude with an argument for demedicalization, looking at how trans services would manifest if they were not treating a medical condition but rather were providing access to necessary medical technologies.

What is Medicalization?

To understand medicalization I am focusing on two works by Peter Conrad. Firstly I will be using their 1992 essay *Medicalization and Social Control,* because it contains a thorough analysis of the relevant (particularly post-1980) literature on medicalization which acts as a foundation. Secondly, I will be pulling from their 2005 article *The Shifting Engines of Medicalization* which provides a more contemporary update to that previous work. While Conrad only mentions transness briefly, I am using

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[129] I delve into the specifics of these bureaucratic barriers in the following chapter.

their theories to understand on a more micro level the way that transness specifically is medicalized. In *Medicalization and Social Control,* Conrad explains that "'medicalization' describes a process by which non-medical problems become defined and treated as medical problems, usually in terms of illness and disorders" (1992, pg. 209). Conditions can be medicalized to a greater or lesser degree and it is a complex process with care providers, researchers, government bodies, patients, and other agents all playing a part. It is a broader social pattern that can be deliberate or unintentional on the part of the medical profession. It is also often a gendered phenomena, as "gender segmentation is a propitious strategy for defining problems and promoting medical solutions, both exploiting and reinforcing gender boundaries", something that becomes especially relevant for trans people (Conrad, 2005, pg. 11). Specifically Conrad identifies three types of medicalization: conceptual medicalization, institutional medicalization, and interactional medicalization. They also differentiate between deviant medicalized behaviors and medicalized behaviors that are part of a natural life course. As for what causes medicalization, they highlight secularization and the nature of the medical profession itself as two possible culprits. Finally they delve into the effects of medicalization as a form of social control and the resulting push-back for demedicalization in some cases, all of which can be understood through and applied to the lens of trans studies.

Conceptual Medicalization

Conceptual medicalization deals with language and the ways in which problems are defined and discussed. One example is the gradual cultural shift from describing addicts as wayward people who have made bad choices to understanding them as sick people struggling with the disease of addiction (Schneider, 1978). This does not require any direct action on the part of the medical profession and is a social rather than a medical realization, although the medical profession may later cosign the medicalization as is the case in this example where medicine has legitimized the diagnosis of addiction as a disease that can be treated. Conceptual medicalization does not necessarily refer to treatment explicitly but rather reframes the "problem" itself. It takes a societal phenomenon and transforms it into a medical disease or disorder with the use of certain types of language. The phenomena is described as an “illness”, definitional power is taken from the individual and given to medical professionals to “diagnose” the “illness”, experiences and behaviors become “symptoms”, and certain associated actions are deemed “treatments”.

In the case of transness, the “illness” is gender identity disorder (or any of the many names by which it goes), which doctors legitimize with a diagnosis using symptomatic criteria such as the experience of “gender dysphoria”, while actions taken by trans people such as hormone replacement therapy and certain surgeries are the “treatments”. Conceptual medicalization can clearly be seen here in the historical “shift” from transness being culturally viewed as a perverse choice and even a criminal offense[130] to a mental illness which has then been cosigned by the psychological profession with the ever evolving diagnosis of different gender identity disorders. The shift is an incomplete one, however, as the state still maintains some control particularly over the process of having one’s gender legally changed, a process they collaborate with medical practitioners to gate keep as I discuss in more detail below.

Furthermore, while the medical profession has taken ownership of transness as an issue for which they are responsible, the U.K. government has come full circle reclaiming transness as a political issue. In 2002 the U.K. Department for Constitutional Affairs (now part of the Ministry of Justice)’s *Government Policy concerning Transsexual People* stated that transness “is *not* a mental illness. It is a condition considered *in itself* to be free of other pathology (though transsexual people can suffer depression or illnesses like anyone else)”. This statement is at odds with the medicalized model of transness accepted by the medical profession. The medicalized model centers on the diagnosis of transness as a mental illness by a psychologist, but this policy document states that the government does not see transness as a mental illness. This would then lead one to believe that the government does not follow the medicalized model, however in practice that is not the case as will be discussed below. The discordance between the government’s own policy and their practice shows the power that medicalization has as a social force. Particularly in the U.K. where there is a

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[130] As mentioned previously, trans people were at risk of falling afoul of anti-gay laws. For a history of this legislation in the U.K. see Peter Tatchell’s 2017 Guardian article *Don’t fall for the myth that it’s 50 years since we decriminalised homosexuality*.

nationalized healthcare system, state and medical social control are complexly intertwined (Harrison and Ahmad, 2000; Abraham, 2009). In this specific context however, being trans has been conceptually medicalized as it has been framed and described as a mental illness and placed under the purview of the medical and psychological professions, a framework that is still dominant despite the government's stance to the contrary[131].

Institutional Medicalization

Institutional medicalization takes place within organizations such as schools, prisons, charities, and various government agencies. A classic example of institutional medicalization would be schools labelling rambunctious children as "hyperactive" and offering ADHD specific accommodations for them. Even with this form of medicalization, as with the school example, the organization may consult medical professionals but it does not require their direct action. In this case "physicians may function as gatekeepers for benefits that are only legitimate in organizations that adopt a medical definition and approach to a problem, but where the everyday routine work is accomplished by nonmedical personnel" (Conrad, 1992, pg. 211). So, while children may require a formal diagnosis to receive services, the actual work of medicalizing these students and separating them from their peers is done by non-medical personnel within the school system (Phillips, 2006).

With trans people, this type of medicalization can be seen in the U.K.'s government bureaucracy. Many trans people want their birth certificate and other identifying documents to reflect their correct gender rather than the one they were assigned at birth. To do this in the U.K. you need to acquire a Gender Recognition Certificate (GRC) wherein you prove to the government that you are indeed the gender you say you are according to their criteria. It is of the upmost importance to note that only binary genders are accepted so non-binary trans people are completely excluded

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[131] In this case, part of the medicalizing process is the naming of the illness. Some may argue that transness per se is not being medicalized here, and that, rather, it is the illness of gender identity disorder (or gender dysphoria or any other name it may go by). However, I argue that there is no gender identity disorder without transness. Thus, what is being medicalized is having gender identity different from the one usually associated with the sex one was assigned at birth. In this way it is transness that is medicalized.

from obtaining any legal recognition. If you would like to change your gender to either male or female, then a doctor's statement confirming a diagnosis of gender dysphoria is required. In the application form medical authority is valued over the authority of the trans person. After all of the usual biographic information and a bizarre section in which you state the date you started living as your gender, there is the required medical report from a practitioner specializing in gender dysphoria then the medical report from a second practitioner not necessarily specializing in gender dysphoria. Only after those does the statutory declaration come, where the applicant legally swears that they are the gender they say they are. It is also important to note that if they are married or in a civil partnership, there is an additional section where their spouse has to sign off, further chipping away at trans people's autonomy[132]. From the fact that this process exists at all to how it is constructed and carried out promotes a medicalized model of transness that is nevertheless not carried out solely by medical professionals.

Another noteworthy intersection between institutions and the medicalization of trans people is in prisons. This is a subject that has received a lot of media attention lately especially after the deaths of Vikki Thompson and Joanne Latham in 2015, two trans women who were placed in men's prisons in the U.K. (Chidzoy, 2015). Trans women who are sent to men's prisons are considered to be at a high risk of harassment and sexual assault and the Ministry of Justice (MoJ) has adapted many accommodations for them, however they are still required to "prove" their gender in order to access these accommodations. The same process of obtaining a gender recognition certificate applies[133] and while the MoJ guidelines have moved away from anatomical definitions of gender toward (to some extent) a model of self-identification, the process to obtain legal gender recognition is distinctly medicalized as I discussed above.

This specific document, *The Care and Management of Transgender Offenders*, offers an interesting glimpse into the way the government discusses trans people. The

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[132] Additionally, this raises questions about what types of relationships the state sees as viable, specifically a disregard for the possibility that someone would want to stay married upon finding out that their spouse's gender is different from what they thought it was when they got married.

[133] There is some wiggle room where they can honor a trans prisoner's transfer request without a gender recognition certificate, although they must still "demonstrate consistent evidence of living in the gender they identify with" (MoJ, 2016, pg. 6).

use of the term “acquired gender”, for example, appears throughout this and many other government documents. The idea that a trans person’s gender is acquired frames it as something to achieve and lends legitimacy to the legal process of having to obtain a gender recognition certificate and funnel through the NHS. A trans person who has not gotten such legal recognition has not “acquired” their gender, a process and language that is never applied to cis people. Additionally, the way this document understands trans men and trans women differently is noteworthy[134]. This document states that it may be “necessary to refuse a transfer to the female estate for a transgender (male to female) prisoner with a GRC”, as it says would be done for any woman who posed a risk to the other women in the prison (Ministry of Justice, 2016, pg. 15). However later it also states that “a female to male transgender offender with a GRC must not be refused a transfer to the male estate…because there are no security grounds that can prevent location in the male estate” (Ministry of Justice, 2016, pg. 15). The pervasive cultural idea that, particularly, trans men are really women is codified in these two lines. The MoJ is saying that a trans women (or any woman) could definitely be dangerous to the other female prisoners and that that possibility needs to be allowed for but that a trans man could never be a danger to other male prisoners. This is distinctly enforcing outdated gender stereotypes (that men are strong and dangerous and that women are fragile and in need of protection) and subtly misgendering trans prisoners (specifically that trans men are women and therefore too weak to be dangerous to other men). This misgendering particularly applies to those trans people who have not been legitimated through the state and medical gatekeepers to obtain a GRC. Throughout this example, the prison system has taken the pervasive medicalized view of trans people and used it to inform their policies and practices without the direct action and influence of medical professionals. This exemplifies institutional medicalization, with the medicalization taking place within the institution of the prison system in collaboration with medical professionals and through adopting medical language and definitions, but crucially, as Conrad notes, the day-to-day medicalization is enacted by non-medical professionals.

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[134] This document does recognize non-binary people but as there are no mixed gender or gender neutral facilities they are not discussed much beyond saying that they should be placed according to their “legal gender”.

Interactional Medicalization

The third and final form of medicalization profiled by Conrad is interactional medicalization which is medicalization that takes place within the doctor-patient relationship. When someone goes to a medical professional with a problem and that professional claims ownership of that problem and says on a very basic level, ’this is what is wrong with you’ (diagnosis) and ‘this is what we [the medical profession] are going to do to fix it’ (treatment), interactional medicalization is taking place. This is where the medical profession is undoubtedly directly involved in the process of medicalization, although it does not need to be intentional on the part of the individual medical professional. Rather, interactional medicalization is embedded in the medical system as a whole. When it is unintentional the medical professionals are simply following their own training, although their actions can also be informed by their own personal feelings and ideologies. It is however the most visible and obvious form of medicalization, particularly to the people experiencing it.

With trans people this happens in every interaction they have with medical professionals. Because many trans people seek things like hormone replacement therapy and different surgeries which have always been wholly claimed by the medical sphere, they must go through the medical system to access them. This is where many trans people can most readily see the impact that the medicalization of their bodies and identities has on their lives as they encounter a medical system that claims them and yet is ill-equipped to actually help them (Women and Equalities Committee, 2016). Interactional medicalization can be seen when trans people go to their General Practitioners (GPs) for help and are diagnosed at least preliminarily with gender dysphoria and are referred to psychologists and/or gender clinics and encouraged on a linear transition path which they see as the treatment for this “disease”. That linear transition consists of starting with a social transition to gain “real life experience” (RLE). A social transition consists of the trans person coming out to their friends, family, and other people in their life as trans. From there it may include changing their name and gender markers on identification, adopting the clothing and hairstyles associated with their gender, using pronouns associated with their gender, and so on. Real life experience is the term the NHS uses to refer to these steps. The patient looking for hormones and/or surgery will at some stage ask their GP for a referral to a gender clinic[135]. Once they wait in the queue and get an appointment they are assessed by a clinician to determine if they have gender dysphoria. Then they need another appointment to get a second opinion from another clinician as well as a physical exam, at which point they would start hormone replacement therapy with either testosterone or estrogen, possibly with hormone blockers as well. Then they would enter the queue for "top surgery" (double mastectomy or breast augmentation[136]) if necessary and later "bottom surgeries" of which there are many possibilities. It is relevant to note here that adhering to or deviating from this partway does not say anything about the person who is embarking on that path, as trans health scholar Ben Vincent notes in their 2018 book *Transgender Health: A Practitioner's Guide to Binary and Non-Binary Trans Patient Care*:

> "It is important that clinicians do not assume that binary-oriented trans people have one discrete set of needs while non-binary trans people have another. Patients should be considered in an individual manner, such that a binary-oriented trans person might want a less typical transition pathway or a non-binary person might want a very traditional transition, without this undermining the reality of their experience of gender" (pg. 165-166).

What is described here is an extremely simplified outline of the path but it represents the way the medical system situates trans people and understands the process of transitioning, as completely binary and linear.

There is another concerning layer to do with the medicalization of transness which is that some medical professionals do not recognize transness (Grant et al. 2010). Due to gaps in their training, personal feelings such as religious or political

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[135] In England, Scotland, and Northern Ireland people can be referred directly to the GIC by their GP but in Wales they still operate tertiary care where people go first to their GP, then are referred to a psychiatrist, and then with the consent of the psychiatrist they go back to the GP for their referral to the GIC.

[136] Many transfeminine people taking estrogen develop breasts and never require breast augmentation or may put it off until after other surgeries that are more urgent for them.

ideologies, or other factors that lead medical professionals to act, to an extent, autonomously, some trans people are turned away. Ben had just such an experience.

> "Once when I was 19, I'm 24 now quite a while ago, I tried to come out to just a general, just a GP and that was a really bad experience because I just you know just kind of luck of the draw. Sometimes you get put with people who understand things and sometimes you don't so I got put with somebody who really didn't understand anything I was talking about and was quite rude to me…it was a terrible experience…he started saying really bizarre things. He looked through my file and he saw that my birth dad is from Bahrain and he started asking me like 'oh people over there they…they're not very accepting of gender and stuff like this they they don't like women' and all these kind of things 'is it because your father treated you badly because you were born woman or something like that?' and I was I was floored. And back then I was not as assertive so I just kind of took it…I was trying to sort of reach out to this person and be like 'I have, I'm having a problem' and they just totally smashed it down. So much so that actually kind of pushed my transition back by quite a few years because I was, I just assumed that what I was gonna get. That was my first experience of it and that's, I guess I assumed that's what I was gonna get going forward so I just didn't kind of, pushed myself back in the closet I guess"

Some trans people have to go through several GPs before they are able to get a referral to a GIC if that's what they are seeking. I argue that this represents the incomplete medicalization of transness. Here the fact that transness is so highly stigmatized is interfering with its medicalization, so while it is medicalized in all of the ways discussed above, it is, ironically, not fully medicalized in the interactional sense since some medical professionals refuse to claim responsibility. When looking at medicalization through a broader lens, however, interactional medicalization remains crucial because while not every medical professional may medicalize trans people, every trans person experiences medicalization, particularly when seeking transition related healthcare.

Deviant vs. Natural Life Course Medicalized Behavior

Another way of understanding medicalized behavior can be with the classification of said behavior as either "deviant" or conversely as part of a "natural life course". The types of medicalized behavior that would be labelled as deviant may seem obvious to cultural insiders but Conrad specifically highlights "madness, alcoholism, homosexuality, opiate addiction, hyperactivity and learning disabilities in children, eating problems from overeating (obesity) to undereating (anorexia), child abuse, compulsive gambling, infertility, and transexualism, among others" (Conrad, 1992, pg. 213). Transness falls into this category of medicalized deviance, and that adds a thick layer of social stigma as opposed to the medicalization of a "natural life process". Emily commented on this very stigma, remarking that "many of us have stuff from childhood of being told that you're, you know, wrong, different, strange, perverse, whatever else you know, not conforming to what your father wants…peer groups at school all sorts of things". She goes on to say that this very experience of stigma made it more difficult for her to face the gatekeeping and bureaucracy of trans healthcare[137]. On the other hand, there are the "natural life processes that have become medicalized" which includes "sexuality, childbirth, child development, menstrual discomfort (PMS), menopause, aging, and death" (Conrad, 1992, pg. 213).

The most distinctive feature of this list is that most of these medicalized natural life processes occur in AFAB people (i.e. the medicalization of childbirth and menstrual cycles) or are socially disproportionately applied to (cis) women (i.e. the medicalization of sexuality and aging), so scholarly and particularly feminist critique of this idea is nothing new. Feminist scholars have long called out the medicalization of natural life processes as a reinforcement of the patriarchy. One critique from Chrisler and Gorman harkens back to a time "when women's occasional irritability, bloating, and pimple outbreaks were normal experiences, part of the ups and downs of everyday life. In those days (before 1980), people thought that women were angry when there was something to be angry about, irritable because something was irritating, and tearful because there was reason to be sad" (Chrisler and Gorman, 2015, pg. 77). Nowadays, these variances which were once seen as normal have become medicalized under the labels of premenstrual syndrome (PMS) and premenstrual dysphoric disorder (PMDD) which they argue is a result of the cultural expectation that women always be calm, thus framing their emotions as symptoms. This can be most clearly seen in the symptom lists themselves. There are so many symptoms, especially for PMS, that it is bound to garner a large number of diagnoses. More interestingly though is that when taken out of context, many of the symptoms (i.e. craving sweet or salty food) could be part of any

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[137] I go into more detail about these bureaucratic processes in Chapter 5.

normal life course, while others (i.e. increased sex drive) are considered positive by many “patients”. Indeed all of these symptoms have one glaring thing in common, which is they would not be considered symptomatic if they were reported by cis men. Even the more serious diagnosis of PMDD is controversial because a) it is hard to determine if the depressive state was linked to a preexisting condition and b) it has a history as a money-making opportunity for pharmaceutical companies (Chrisler and Caplan, 2002). This critique of natural-life course medicalization does not mean the “issue” doesn’t exist, that people don’t experience these “symptoms”, rather that medicalizing the “issue” is not productive and is potentially harmful to the people who experience the medicalized phenomena. In this case it allows for the medically sanctioned stigmatization of people who menstruate and the dismissal of their feelings as valid and normal. This is just one specific example but there are further critiques of the medicalization of pregnancy (Barker 1998), childbirth (van Teijlingen et al., 2004), sexual desire (Wood et al., 2006), and menopause (Meyer, 2001), in a similar vein.

These arguments are aided in large part by the “high ground” position of being able to condemn the medicalization of these “natural life course” events. It is easier to argue for the demedicalization of processes that are common, unavoidable, or are otherwise viewed as “natural”. Transness on the other hand, according to Conrad, falls into the second category of deviant medicalized behavior and it is the added stigma surrounding this category which complicates critiques of medicalization. Conrad categorizes transness with things like drug and alcohol addiction and child abuse, which is very telling in relation to how transness is viewed socially. Trans people have been, and to many extents still are, seen as deviant, as having something wrong with them. This category of deviance helps to justify their medicalization through framing transness as a problem that medical intervention can solve (Conrad, 1992).

This is a very useful analysis, however I argue that Conrad has missed a category here. I would add to this discourse the category of a “deviant life course” under which transness (and homosexuality for that matter) would fall. The exploration and understanding of one’s gender identity is a part of the natural life course. It is simply a part of life that has a rich history of being suppressed and demonized. In this way transness does not fit into the “natural life course” category because while people medicalize say pregnancy or menstruation, they are not denying that they are natural phenomena that exist. Transness also does not fit the “deviant” category simply because it isn’t. It makes sense from a sociological point of view but not from the point of view of trans people themselves. Unlike other medicalized behaviors in the deviant category there is nothing about transness that is harmful to others (as is the case with, for example, child abuse) nor anything that is harmful to the person themselves (like with drug and alcohol addiction). It is simply one possible result of the natural life course event of venturing to understand one’s gender which has been labelled deviant by society. The positioning of transness as this deviant life course offers some explanation of why it has become medicalized as well as why proponents of the demedicalization of transness face so many obstacles.

Secularization and Medicalization

One theory of medicalization causation that Conrad addresses is the theory of secularization, or the idea that increased medicalization is the result of the gradual cultural shift away from the church as the leading societal authority. This theory states that as society has become less and less centered around a religion, in the case of the U.K. Christianity, that the authority of science and medicine has swooped in to fill that void. Behaviors that were once classified as sins such as suicide have become reframed as sickness, in this case depression or other mental illness that is understood to cause suicide (MacDonald,1989). This seems to be a bit of an oversimplification however. Religion continues to be an influential force in many people’s lives and can, along with other forces, wield influence over the medical profession as was the case with the medicalization of homosexuality. In the 1970s, after centuries of homosexuality being labelled both a sin and a mental illness, the harmful effects of those entangled designations were finally widely recognized and homosexuality was gradually demedicalized (Drescher, 2015). The British Medical Journal sought to understand the implications of the medicalization and came to the following conclusion: “Our study shows the negative consequences of defining same sex attraction as a mental illness and designing treatments to eradicate it. It serves as a warning against the use of mental health services to change aspects of human behaviour that are disapproved of on social, political, moral, or religious grounds" (Smith et al., 2004, pg. 3). This recognizes that even in today's more secularized society, religious and other ideologies can strongly influence which behaviors are labelled as deviant, making those behaviors prone to possible medicalization.

With transness, much of the fierce debate over trans rights has come from some claiming that trans people have a disease that can and should be treated, with others, particularly on the religious right, claiming that they are choosing a deviant lifestyle (of course many trans people are claiming they are neither diseased nor deviant). The very existence of this debate shows that medicalization has not replaced anything but that there are multiple sources of societal authority coexisting and clashing at once. As Conrad puts it, "while it is true that medicine is in important ways nudging aside religion as our moral touchstone, the interface of medicine and religion is more complex than a simple secularization thesis would suggest" (1992, pg. 214). Many people when sick will turn to both medicine for treatment as well as prayer or other religious activities.

The Nature of the Medical Profession

There has certainly been a shift in the dominant knowledge producing authority towards the scientific method and the medical profession but its relationship to other authorities and the cause of its rise to dominance remains complex. Another theory involves the nature of the medical profession itself. This posits that the medical profession is purposefully over-medicalizing in order to increase business in an increasingly healthier world (Pawluch, 1983) or to make clinical work less ordinary and routine (Halpern, 1990). Pawluch and Halpern specifically discuss the interesting case of the expansion of the field of pediatrics.

In *Transitions in Pediatrics: A Segmental Analysis*, sociologist Dorothy Pawluch proposes that medicalization has been a crucial life raft for practicing primary care pediatricians in a time when child mortality and morbidity is at an all time low, in the United States in particular. This decrease in child mortality and morbidity is obviously a very positive thing but the reality of medicine as a business is that it relies on sick people to treat, so a healthier juvenile population could have threatened the specialty of pediatrics. Pawluch theorizes that "primary care pediatricians in the United States survived by broadening the scope of pediatric practice to incorporate the management of children's troublesome behavior" (1983, pg. 450). This represents a medicalization of childhood behavior (or rather misbehavior) and shifting it from the domain of parents, schools, and/or the legal system to the domain of the medical system. These problems are not necessarily biological but developmental and emotional issues including hyperactivity, not fitting in with peers, and struggling academically. This created new diagnoses like attention deficit disorder (ADD)/attention deficit hyperactivity disorder (ADHD), dyslexia, oppositional defiant disorder (ODD) and others as well as their corresponding treatments which can include pharmaceuticals. With this shift "the mandate of pediatrics was extended beyond the treatment and prevention of childhood disease to include the positive promotion of child health in all its dimensions" (Pawluch, 1983, pg. 461). This new holistic model of pediatrics has not been universally accepted: many within the medical and academic professions were and continue to be critical of its necessity and potential to do harm with over-diagnosis, however with over twenty years perspective since Pawluch wrote about this emerging trend it is clear to see that it has indeed taken root and become dominant.

In their 1990 article *Medicalization as Professional Process: Postwar Trends in Pediatrics*, sociologist Sydney Halpern discusses the emergence of "the new pediatrics", an increased focus of the psychosocial problems of children by pediatricians in postwar (late 1950s) America. This article discusses how market, academic, and other forces spurred the creation of specialists and the "new pediatrics" which discouraged general practice in favor of promoting subfields based on scientific research. Halpern states that "by extending their claims over social problems, pediatric leaders sought to reconcile the disparity between education and practice and to make routinized clinical work appear more challenging" (1990, pg. 38). This phenomenon seems to value the academic and research knowledge contribution to the field more than knowledge contribution coming from pediatric practice[138]. Their role as pediatricians becomes expanded through the treatment of new disorders such as ADD and the other ones already discussed, but their role is also made more important by

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[138] Some pediatricians participate in both research and practice, so this is referring to modes of knowledge production within pediatrics that different individuals may participate in at different times rather than grouping individual pediatricians as only either academic/research or practice based.

positioning pediatricians as the overseers of a child’s holistic wellbeing, delegating interventions or “treatments” to parents, schools, and counsellors while being the primary collaborator. This leads to a more challenging, intellectually stimulating, and prestigious job. Halpern also sees this relationship going both ways, with academia influencing the practice of pediatrics as well as physicians influencing academia by publishing their own research. In fact they predict that “as funding agencies address social "disorders" such as poverty by channeling resources into behavioral medicine, social scientists may encounter increasing difficulty in obtaining support for research that applies nonmedical perspectives to such problems” (Halpern, 1990, pg. 39). Again with many years of perspective, while the medicalized model does not have a complete monopoly on the academic discussion of psychosocial problems, it is certainly dominant. Trans children are a fairly new frontier that pediatricians have broached, and they offer the creation of a new area of expertise and specialization. By Halpern’s theory, the reason for this would be to break up the mundanity and increase the prestige of the field of pediatrics, being influenced by the academic branch of pediatrics that discusses trans children in an almost exclusively medicalized way. These two perspectives along with the notion that medicalization is a natural product of the medical system can help frame the discussion of trans people’s experiences with that medical system.

Medical Social Control

This causation model also fits well with the theory of medical social control. Like any form of social control, medical social control uses certain pressures to enforce societal conformity and medicalization is the tool used to apply those pressures. Conrad highlights four types of medical social control which are specifically used to medicalize deviant phenomena; ideology, collaboration, technology, and surveillance. Medical ideology applies a medical framework to a perceived social problem, as opposed to a religious or a legal ideology being enlisted to deal with that problem. The more that social “issues” like drug and alcohol addiction, aging, and gender variance are explained using a medical ideology and medical discourses the more that medical ideology becomes one of the dominant social belief systems. Medical collaboration places doctors as decision makers and gatekeepers of things like benefits and jobs. A good example of this is employee drug testing. Medical technology includes the use of pharmaceutical and other interventions. This can be anything from the development of better antidepressants to improvements in prosthetics to new surgical techniques. Medical surveillance is constantly being subject to what Michel Foucault famously called the "medical gaze" which separates the person's body from the person themselves and highlights the dehumanizing experience of medical observation. The societal perception of this gaze is what gives physicians and other medical professionals much of their clout:

> "…it was this constant gaze upon the patient, this age-old, yet ever renewed attention that enabled medicine not to disappear entirely with each new speculation, but to preserve itself, to assume little by little the figure of a truth that is definitive, if not completed, in short, to develop, below the level of the noisy episodes of its history, in a continuous historicity. In the non-variable of the clinic, medicine, it was thought, had bound truth and time together." (Foucault, 1973, pg. 54-55)

This gaze is a tool of medicalization and promotes the idea of science and medicine as the dominant societal knowledge producing systems.

With their training and vast experience "gazing" upon trans bodies, medical professionals are considered the experts on trans people. From the perspective of experiencing the medical gaze, this is something trans people know all too well as they are constantly identified in society and within the medical system by their physical bodies, rather than being allowed to identify themselves, and are time and again reduced down to sex characteristics. The value that is placed on the medical gaze devalues the knowledge trans people have of themselves, a knowledge which rejects the body as end-all and be-all and instead is built on lived experience. These forms of medical social control, whilst having their own negative outcomes such as increased stigma and barriers to accessing services, can seem kinder than other forms of social control. For example treating drug addicts as sick patients is surely better than treating them as criminals. It often seems like a softer, kinder way of treating the medicalized people. However, legal and medical social controls are too often intertwined as is the case with the example of drug addiction. With trans people, medicalization is certainly better and kinder than throwing trans people in jail, but medicalization is in many ways just a lesser evil. Other pervasive societal forces are also wrapped up in medical social control, such as ageism and the medicalization of the natural aging process, sexism and the overmedicalization of AFAB people's bodies, and the condemnation of certain "deviant behaviors" such as transness. The alignment of these societal views with medicalization calls into question the alleged purity of the science based medical system. While it is certainly a powerful tool for social control, if medicalization is indeed so aligned with societal values then it is also susceptible to the shifting of those values and targeted attempts to demedicalize certain phenomena as I will discuss in the following section.

Demedicalization

As has largely been the case thus far in this discussion, the term medicalization is often used in a critical sense to discuss ways in which aspects of life, personhood, or behavior become unnecessarily labeled as "illness" which is assigned "treatments", and the harms that can result. However, any and every illness that is medically treated today has been medicalized. As Conrad says,

> "While 'medicalize' literally means 'to make medical' and the analytical emphasis has been on overmedicalization and its consequences, assumptions of overmedicalization are not a given in the perspective. The main point in considering medicalization is that an entity that is regarded as an illness or disease is not ipso facto a medical problem; rather, it needs to become defined as one." (Conrad , 2007, pg. 5-6)

The issue is not simply with medicalization itself but rather with how liberally it is applied. For something to fall into the domain of the medical profession there needs to be an illness with diagnostic criteria and there needs to be a treatment or cure administered by the medical profession. Medicalization is the process of fitting something into that box; some phenomena fit very neatly and others have to be forced in. As one of thousands of possible examples, tuberculosis has been "medicalized" over hundreds of years as it has been described in medical terms, studied, diagnosed, and treated by the medical profession, but no one is arguing for the demedicalization of tuberculosis. Indeed, some patient advocacy and support groups fight for medicalization, for example with chronic fatigue syndrome (Broom and Woodward, 1996) or repetitive strain injury (Arksey 1994). In cases like these patients want medical professionals to recognize, legitimize, and treat seriously their symptoms. The fact that some groups are working toward the medicalization of their experiences while others are arguing for demedicalization is not a contradiction because medicalization is not inherently good or bad. As sociologists Ballard and Elston note, it is simply that "there seems to be oscillation between medicalisation and demedicalisation of many aspects of everyday life", and that this constant patient-led renegotiating of what should and should not be medicalized is a facet of our post-modern society (2005, pg. 238). Medicalization only becomes problematic when it causes stigma and discrimination and puts up barriers to what becomes labelled as "treatment".

With trans people, there is a clear parallel to be drawn between the medicalization of gender variance and the history of the medicalization of sexuality variance. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), while mostly used in the United States, is globally influential. For example, from its inception in 1952 until the third edition (DSM-III) removed it in 1973, homosexuality was listed as a psychological disorder. The General Assembly for the WHO did not remove homosexuality from the International Classification of Diseases, which is used by the NHS in the U.K., until 1990 (Drescher, 2015). This is an example of the medical profession acting in accordance with dominant societal paradigms and later shifting when those paradigms shifted. Conrad refers to this type of process as demedicalization: the undoing of the process of medicalization such that the "problem is no longer defined in medical terms and medical treatments are no longer deemed to be appropriate solutions" (Conrad, 1992, pg. 224). The idea that homosexuality (and transness) are psychological diseases that can be cured is the exact same ideology that leads to harmful conversion therapy and of course the medicalized model used by the NHS. The NHS model which seeks to "treat" transness in a way that affirms trans people's gender is of course not as harmful as conversion therapy which rejects trans people's gender and seeks to "treat" transness through making people cis, however it is the underlying idea that transness requires any type of treatment in the first place that is the issue. In the case of homosexuality, demedicalization was achieved by a concentrated, well-organized political effort which simultaneously challenged the medical system and society as a whole to recognize gay and lesbian people as normal members of that society. It was certainly not easily attained and trans people who want to follow suit with the demedicalization of transness may face an even tougher battle.

The Normal and the Pathological

The ability to medicalize deviant, abnormal, or pathological phenomena relies on a definition of the pathological and therefore a definition of the healthy or the normal. French physician and philosopher George Canguihem addresses this difficult question in their aptly titled 1991[139] book 'The Normal and the Pathological', where they partially explain disease as "characterized by the fact that it is a reduction in the margin of tolerance for the environment's inconstancies" (pg. 199). Disease or pathology is that which effects someone's ability to be in their world comfortably and competently. While gender doesn't inherently impact one's flexibility within the environment, gender non-conformity can make one unable to blend into that environment.

If that is the pathological then what is its apparent opposite? Canguihem defines health and physiological norms as such:

> "If we acknowledge the fact that disease remains a kind of biological norm, this means that the pathological state cannot be called abnormal in an absolute sense, but abnormal in relation to a well–defined situation. Inversely, being healthy and being normal are not altogether equivalent since the pathological is one kind of normal. Being healthy means being not only normal in a given situation but also normative in this and other eventual situations. What characterizes health is the possibility of transcending the norm, which defines the momentary normal, the possibility of tolerating infractions of the habitual norm and instituting new norms in new situations." (Canguilhem, 1991, pg.196-197)

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[139] This book was originally published in French in 1966 under the title *Le Normal et le Pathologique* but I am referencing Carolyn R. Fawcett's 1991 translation here.

The pathological to Canguihem is not abnormal or the absence of a norm, but rather a new and different type of norm. Therefore "disease is not merely the disappearance of a physiological order but the appearance of a new vital order” (Canguilhem, 1991, pg. 193). They also challenge the temptation to conflate ‘normal’ and ‘typical’: "a human trait would not be normal because frequent but frequent because normal" (Canguilhem, 1991, pg. 160). To understand this theory through gender diversity we can explain that the pathology of gender identity disorder is just a different way of being gendered, the way that any bodily pathology is just a different mode of embodiment. Being cisgender is the most common state and has therefore become conflated with the normal state when in fact gender variance and gender exploration is also a norm. The issue is not with gender diversity (the “pathology”) but only with the instances and ways in which it causes distress to the person experiencing it. This distress is not inherent but arises when the trans person comes up against a society that does not accept them or indeed actively discourages their existence.

If the goal of medicalization is to cure the medicalized phenomena and “in principle, curing means restoring a function or an organism to the norm from which they have deviated” (Canguilhem, 1991, pg. 122), then what is that norm from which a trans person has deviated? Canguilhem goes on to explain that “the physician usually takes the norm from his knowledge of physiology–called the science of the normal man–from his actual experience of organic functions, and from the common representation of the norm in a social milieu at a given moment” (1991, pg. 122). So the norm is simply that state which is physically and socially common. The influence of the social is crucial here, and Canguilhem stressed that “in dealing with human norms we acknowledge that they are determined as an organism’s possibilities for action in a social situation rather than as an organism’s functions envisaged as a mechanism coupled with the physical environment” (1991, pg. 269). As was discussed previously, this came into play with the demedicalization of homosexuality. Medical professionals recognized the shifting social norms at that historic moment which influenced their diagnostic practice. Perhaps transness will similarly come to be seen as normal human variation the way sexual orientation has, medically and more broadly.

A key part of this definitional struggle is finding the line between pathological difference and individual variation. In other words, ”how do we understand the norms peculiar to each species, rabbits, for example, without erasing the slight, fragmentary dissimilarities which give individuals their singularity?” (Canguilhem, 1991, pg. 261). This can partially be achieved by comparing each individual against themselves because "the borderline between the normal and the pathological is imprecise for several individuals considered simultaneously but it is perfectly precise for one and the same individual considered successively” (Canguilhem, 1991, pg.182). The resting heart rate of a young Olympic athlete may differ greatly from that of an elderly, sedentary person but neither is pathological for them, but if they were to switch heart rates that might be cause for concern. What the specific threshold is for any individual cannot be arrived at objectively: “it is always the relation to the individual patient through the intermediary of clinical practice, which justifies the qualification of pathological” (Canguilhem, 1991, pg. 229). The pathological is necessarily created through the intervention of clinical practice, through the process of medicalization. The “patient” is an active agent in this process of the construction of pathology.

> ”we think that medicine exists as the art of life because the living human being himself calls certain dreaded states or behaviors pathological (hence requiring avoidance or correction) relative to the dynamic polarity of life, in the form of a negative value. We think that in doing this living human being, in a more or less lucid way, extends a spontaneous effort, peculiar to life, to struggle against that which obstructs its preservation and development taken as norms.” (Canguilhem, 1991, pg. 126)

The agent here determines their own pathological states and struggles against them but always with the input of social norms and with the aid of the medical system. So what then is the fate of an agent trying to redefine their own “pathology" outside social norms and against the consensus of the medical system?

The Unique Challenges of the Trans Case

The key difference between the medicalization of homosexuality and the medicalization of transness is that LGBQ+ people are not seeking anything en masse from the medical profession. There is nothing that has been labelled as a treatment which requires a diagnosis of homosexuality the way that HRT and certain surgeries require a diagnosis of gender dysphoria. That is where the unique challenge of demedicalizing transness lies. LGBQ+ people, particularly gay men, have lobbied for things like better sexual healthcare and proper HIV/AIDS treatment and prevention, but crucially these things were never withheld pending a psychological diagnosis of homosexuality. In this way the medicalization of an illness like HIV/AIDS can be separated from the medicalization of the gay men themselves. The one exception is people who historically have sought to be cured of their homosexuality, however those cases can most often be linked to social and/or medical coercion and conversion therapy is now largely condemned (Smith et al., 2004). LGBQ+ people were completely unwilling casualties of medicalization and were therefore better positioned to effectively organize and fight it.

Trans people on the other hand are often seeking hormone replacement therapy, psychological therapy, and surgeries, all things firmly claimed by the realm of medicine. It is essential that any argument for demedicalization ensures the continued (and ideally improved) access to these interventions. As Adam describes, the experience of living before having accessed these crucial interventions:

> “…makes it so that I am so incredibly uncomfortable on a regular basis you know, it is with me every moment of every day. Like from getting up in the morning and getting in the shower to you know throughout the day wondering if you know my binder is hiding my chest enough and constantly worrying about that to you know wondering if the shopkeeper is gonna think my voice is low enough for a man or if he's gonna misgender me to having to get ready for bed at night and you know take my clothes off again, it is there constantly”. (Adam)

It should not be taken lightly how important it is for people to be able to easily access the hormones and surgeries they need. Currently, in order to access these interventions, they must go through medical gatekeepers and the golden ticket is a diagnosis of gender dysphoria. For transness to become demedicalized by Conrad’s definition, not only would transness have to stop being described and understood in medical terms as a “disorder” but medical treatments would have to no longer be considered “appropriate solutions”. The first half of this is simple enough to understand as gender dysphoria is already a strange case as it is a diagnosis of request. Ben described that the “therapist will pretty much always give you the go ahead because why not? I don't know…they’re very lax I think it's a bit like informed consent…are you trans? Yeah”. Having a disease that you have to seek out to be diagnosed with is certainly not typical, but it is the second half that causes some difficulty. To go through the same channels as homosexuality and fight for the demedicalization of transness without a major change in the medical system or without their cooperation could actually take trans people backwards by endangering access to those “appropriate solutions” (hormones and surgeries[140]) which are so crucial for some trans people.

This is absolutely critical as the mere fact that trans people themselves seem to freely seek out the diagnosis of gender dysphoria has been used as evidence of its validity[141]. This is a fallacy because the medical system created this diagnosis for a group of people with specific needs and then made it the only avenue for having those needs met; so when trans people seek out a diagnosis of gender dysphoria they are not proving the validity of that diagnosis at all but are rather only proving that a. some trans people want and need therapy, hormones, surgeries, etc. and b. that a diagnosis of gender dysphoria is the only way to access those things. The only actual evidence for or against the validity of the diagnosis of gender dysphoria can be found by talking to trans people themselves, a source of knowledge that has been tragically underutilized.

In addition to listening to trans people and valuing their expertise about themselves, for demedicalization to be achieved, the therapy, hormones, and surgeries that are currently labelled as treatments need to be reframed as services while still being made available to trans people. In fact this would increase the people they would be available to as non-binary people and others not seeking a “traditional” transition path would have easier access in this scenario. This would be incredibly difficult but not as ‘out there’ as it may seem, especially in countries with greater social safety nets. When people can not afford to feed themselves or their families, society helps them out

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[140] Access to therapy and mental health services would be easier as those are separately existing parts of the NHS.

[141] For example this happened at Harry Benjamin’s clinic in the 1960s which I discuss in more detail in Chapter 6 (Stone, 1991/2006).

with food assistance programs. Parents who can not afford private school can send their children to the local public school. Of course the effectiveness of these programs in the U.K., especially in recent years, can be quite rightly critiqued, but the societal value of providing essential services to those in need is what is relevant. None of these services require a medical diagnosis to access because the services provided have not been claimed by the medical system. If that statement seems unnecessary and if what is and is not claimed by the medical system seems inherent and obvious, then imagine an even more highly medicalized world where food assistance programs are run by nutritionists and schools by developmental psychologists. Realms of authority have always been malleable: childbirth has shifted from the responsibility of the community to the responsibility of medicine (van Teijlingen et al., 2004), addiction and alcoholism have moved from purely the realm of the legal system to shared responsibility with the medical system (Tournier, 1985), and homosexuality has moved from the sphere of the legal system to the sphere of the medical system, then became demedicalized, briefly remedicalized during the early years of the HIV/AIDS crises, firmly demedicalized again, and is now in the sphere of the political system (Conrad and Angell, 2004). There is nothing inherent about the gatekeepers society assigns to the access of certain services. In the case of medical services, these gatekeepers come about through processes of medicalization. As I discussed earlier, defining a phenomenon as an illness installs diagnosis as a “gate”, or barrier to accessing what becomes labelled as treatments. This diagnostic process is overseen by relevant medical professionals who become the gatekeepers, either allowing or disallowing people to access “treatments” (in this case hormones and surgeries). If the phenomenon is labelled as a mental illness, these professionals will be psychiatrists, psychologists, and other mental health professionals. This medicalized model of transness has been normalized, but if the act of giving hormones and performing surgeries is thought of as a technical skill and the medical professionals who provide them as technicians offering a service rather than curing a disease, there would be no need for this diagnostic process and a lot of the harmful rhetoric around transness would cease to be relevant.

If the stereotypes and misinformation about trans people were no longer being cosigned and perpetuated by the medical system, which as we have seen is a very powerful societal force, then perhaps the rest of society would follow suit. Trans people would no longer be “sick” people in need of treatment, the binary and linear transition would no longer be the privileged path, and most importantly trans people would no longer have to “prove” their gender to anyone. This would be a massive change as the current process of acquiring a diagnosis of gender dysphoria requires convincing at least two medical professionals that you are indeed the gender that you claim to be, or more accurately in many cases, that you fit into a highly stereotyped caricature of a binary gender role. It would also remove the need for trans people to socially transition first before accessing these services, which is not safe for everyone to do. Currently, to access a diagnosis of gender dysphoria, people have to start dressing, presenting, and living as their gender (a strange idea that is often poorly defined), even if doing so will render their transness visible in contexts in which being visibly trans is unsafe (such as those described in Erlick, 2019). The phrase “real life experience” itself also shows a misguided view of what transness is. If gender is something that is inherent, which the medical system seems to think it is as they provide irreversible medical interventions for trans people, then trans people have their whole lifetime worth of “real life experience”. As discussed in the previous chapter, the medical profession likes to promote the ‘trapped in the wrong body’ trope, the idea that, for example, a trans woman is a woman trapped in a man’s body or that she was born in the wrong body. In other words that a trans woman was born a boy and requires experience living as a girl/woman before they can be sure they want to transition. Many trans people have challenged this and said that they have always been their gender, that in this example trans women are born women, just in a different body from the one society expects them to be in, and they may or may not want to change their body to coincide with the body society expects women to have.

Real life experience refers only to experience playing into the stereotypical role of your gender, or as Ruth Pearce explains, “[underpinning] RLE is the presumption that trans people *can* and *should* maintain a consistent (ideally cis-passing) gender identity and gendered appearance” (2018, pg. 200). There is, after all, so much more to the experience of being a woman than wearing dresses and having a feminine sounding name. Emily said that upon seeing the results of her first appointment with a psychiatrist to get a referral to the GIC she was surprised to see that “the psychiatrist wrote a report out of it, having misheard much of what I said, and an itemized description of what I was wearing you know…’the patient presented as female’ and in all these little minuscule aspects it was it was interesting to be objectified in that way”. This idea of real life experience is especially difficult for non-binary trans people to navigate. They are erased throughout the medical system but it is especially glaring here. What exactly would real life experience look like for a non-binary person? There is no gender role or expectation for being non-binary and most non-binary people can never pass because society at large does not see being non-binary as an option. They are consistently read as either male or female. The very existence of non-binary people challenges a lot of the existing narratives that society and the healthcare system hold about trans people so the fact that they are erased is not all that surprising as they don’t fit neatly into existing boxes. It does not make it any less harmful though as non-binary people struggle to access transition related healthcare and more generally to navigate a world that is not arranged to fit them. In this case the medical system fully recognizing non-binary people and accommodating them would be a huge leap forward for trans people and might help them gain other rights in addition to better healthcare.

By removing the multiple gate keepers the legitimation of these types of rhetoric would no longer be necessary[142]. But the remaining issue would still be how trans people would go about accessing these services should they need them. This is a concern shared by the clinicians providing this care, as I discussed in Chapter 2. Most people can not afford to self fund their transitions which can cost tens of thousands of pounds. Some people are able to community fund their surgeries by raising money from friends, family, and even strangers, usually online through social media and sites like Go Fund Me, but this is not a viable option for every trans person. Why shouldn’t these life-saving services be offered to anyone who needs them? One hypothetical reason could be a concern that trans people are just going to change their mind. That allowing, for example, a trans woman to get breast augmentation without going through the lengthy process of referrals and second opinions and so on would be harmful if she ever

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[142] Removing gate keepers does not mean that clinicians would play no role but merely that their tole should be relegated to the very important job of providing whatever care they are expert in with informed consent rather than gate keeping which consenting people can access that care.

changed her mind. However, this is a concern that is never leveled at cis women who want to seek breast augmentation for the same reasons. Being able to have breasts has been asserted as a right that all women should have, which we can see from the fact that breast cancer survivors are offered reconstructive breast surgery as standard, so to deny this right to trans women is obviously treating them differently than cis women who do not have breasts. These cis breast cancer survivors do not have to get a second opinion on their gender and prove to the NHS that they are indeed women, so why do trans women? In a similar vein trans men and other transmasculine people run into the same roadblocks when trying to remove their breasts. So perhaps it goes even deeper than the idea that women have the right to have breasts but rather that they must have breasts, so transmasculine people, being seen as women, struggle to access double mastectomies. Dan explained is as follows:

> “And actually going privately one of the things that I found absolutely absurd was that in order to have the double mastectomy I needed to take in…a letter saying that I was of sound mind to have that surgery but if I wanted to be Jordan[143] and have an enlargement that was like twice the size of my head fine they would have given it to me you don't have to have any kind of checks for that and I remember saying to quite a few places like that is ridiculous I can walk around like a freak and you guys will let me do it and the only response was we can add stuff to your body we're just not allowed to take stuff away which that was just nuts I just want to look like a real guy”

Dan perfectly highlights the frustration of being treated differently than people seeking similar procedures simply because his procedure was related to his transness. Sometimes our bodies have and/or lack things that cause extreme distress and rectifying that is a valid use of biotechnology that should be available to all on an informed consent basis[144]. People changing their mind after these procedures or de-transitioning is thought to be quite rare, but even if de-transitioning were a major concern, the way to address it would not be the adding of more gatekeepers. It would

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[143] A British celebrity with famously large, surgically enhanced breasts.

[144] See Cundill and Wiggins, 2017 for an example of the informed consent model as it applies to HRT, however I would expand this to include puberty blockers and surgeries as well.

be to tackle the horrible social stigma that plagues people who do not “pass” and to not force people to choose between a linear, binary transition or none at all.

There is certainly some progress that has been made. Ruth Pearce notes that the NHS is already moving toward depathologization[145], although not quite demedicalization. The depathologization movement:

> "can be understood as primarily concerned with de*psycho*pathologisation: its proponents don’t want to remove access to medical interventions for transitioning individuals, but rather aim to see trans health being understood and treated differently” (Pearce, 2018, pg. 185).

George echoed this in our conversation when he asserted, “I don't think it's a mental health issue at all I think it's totally separate but, it's so difficult to get [psychiatrists] to separate it in their minds”. Demedicalization on the other hand takes it a step further. As opposed to depathologization which seeks to stop labelling transness as a mental illness but to continue offering trans services as medical interventions, demedicalization seeks to redefine those interventions as not inherently medical at all[146]. It is moving from being medicalized as a mental illness to being medicalized as a physical illness or perhaps as some other category of illness versus ceasing to be medicalized at all. Thus the existing progress that Pearce has identified, while very positive, can best be labelled as depathologization, not demedicalization. Trans healthcare providers are openly recognizing that transness is not a mental disorder and that non-binary and fluid gender experiences are increasingly being recognized within trans healthcare.

> "The depathologisation movement has therefore seen several successes in the UK, including shifts away from pathologisation in gender clinic care pathways, somewhat more progressive national protocols for Scotland and England, and possible amendments to legal gender recognition. These changes have been made possible through extensive negotiation both within the UK *and* on an

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[145] This depathologization is supported by many clinicians working in the GICs, as I discussed in Chapter 2.

[146] Interventions being redefined as non-medical removes them from the framework of being treatments for an illness that requires a diagnosis. This does not mean that they are removed from the framework of expertise. Surgical interventions in particular would still need to be carried out by highly-qualified, trained, and ethical experts. As Ben Vincent notes, “[e]ven under [an informed consent] system, guidance, support, and competent practice are still absolutely needed” (2018, pg. 190).

> international level. They rely upon a restructuring of macro-level power relations through the establishment of trans knowledges as credible. However, the *delivery* of gender identity services in the UK continues to rely on an extensive process of gatekeeping, which broadly maintains the micro-level power differentials between practitioner and patient". (Pearce, 2018, pg. 192-193)

These successes are certainly to be celebrated but as Pearce noted there is a long way to go, namely by removing gatekeeping. Removing the diagnosis of gender dysphoria but continuing to offer services to those trans people who require them within an informed consent model[147] would remove these gatekeepers and could go a long way toward the destigmatization of trans people in the same way that the demedicalization of homosexuality did for LGBQ+ people. It would certainly be an uphill battle but I look forward to a day when the medicalization of transness is viewed to be as outdated as the medicalization of homosexuality is generally viewed today.

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[147] As I explained earlier, the informed consent model can be used to access interventions from skilled practitioners beyond the framework of illness and treatment.

Chapter 5: Bureaucracy, Time, and Space

“I paid into a system with the understanding
that I was paying into something that would
help me. If it wasn’t gonna help me, regardless
of whether or not I paid into it, then at least
damn well tell me right from the start ‘we’re not
gonna help you this isn’t what we cover’ and then
I can go someplace else, but don’t keep
throwing me about.” (Dan)

“Plumbing is not gender-neutral”
(Crawford, 2015, pg. 65)

In this chapter I build upon the previous chapter by looking at three functions of social control as they are present in the lives of trans people in the U.K.: bureaucracy, time, and space. The data and theorization presented here supports existing work by Preciado, Vincent, Naugler, Pearce, Adam, Israeli-Nevo, Crawford, and Munt and extends that by Varela, Brown et al., and Maister to apply to gender, transness, and transition related healthcare. Specifically I focus on the varied elements of the medical bureaucracy which prevent trans people from accessing quality healthcare, waiting and wait times, waiting rooms, and bathrooms. In different ways a lack of control over each of these elements block trans people from good health and in combination they highlight the dire state of trans healthcare in the U.K.

Bureaucracy

Framing trans healthcare as a bureaucracy illuminates many of the structural barriers trans people face. The bureaucracies I am describing here are all the NHS and private health care pathways that trans people encounter and the relationship between those pathways, primarily GP surgeries, GICs, and mental health services. Just the prospect of having to engage with these bureaucracies can be enough to dissuade people from advocating for themselves. For example, George describes not pushing his GP surgery when they continued to have his title wrong in the system, an experience I have also had.

> “[W}hen you feel like you're climbing up this massive hill, you let the little things go sometimes. Which you shouldn't because they do make you feel really bad and I dread my name coming up on that screen cause everybody's gonna be like ‘what?'. I just hope people think it's like an admin error, cause it's difficult when I go to pick my prescriptions up and it's actually Ms. you know it's just strange, very strange” (George).

In addition to this sort of general challenge, there are certain features of these bureaucracies; cancelled appointments, the exercise of ticking boxes, having to jump through hoops[148], and the shifting of responsibility, that have been flagged by the participants as points of frustration for trans people. Of course these bureaucratic features will be found throughout many healthcare services, but accessing transition related healthcare increases some trans people’s exposure to these bureaucracies. Furthermore, some features are more present in trans healthcare as I will discuss below, such as the shifting of responsibility which is exacerbated by a lack of understanding from GPs and other healthcare providers about GICs and how they operate.

Cancelled Appointments

A specific complaint about the system was appointments being cancelled at the last minute. Dan experienced this issue when he organized regular appointments at the request of the psychiatrist only to have that schedule disrupted by cancelled appointments. He explains:

> “She gave me an array of times and she said ‘probably monthly's better’ and I was like ‘yeah yeah monthly's good’. And then I got an appointment two months later and you're just kind of like wait, you said monthly. And then that’s, so it was like literally say the beginning of August I had an appointment, the next wasn't booked until like the end of September, no middle of October, and then there was supposed to be another one booked for December which got cancelled.” (Dan)

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[148] I use the more colloquial phrase “jumping through hoops” because this specific phrasing was used by one of my participants and it concisely encapsulates the idea of having to complete a series of actions which are either purposeless or where the person completing them is unaware of the purpose.

He experienced a difference between the care that he expected, the care the doctor said was appropriate, and the care he actually received, both through appointments not being available monthly and then through the appointments that were booked being cancelled. He has also had two other appointments at the GIC cancelled, one far in advance but with no explanation and one very last minute.

> "So I was supposed to be there for 2:30, they phoned me up at nine o'clock in the morning was like, 'we wanted to let you know because you travel from so far away', okay great *pause* fantastic. So I've already waited and now I'm not getting the appointment, and never mind the fact that I was supposed to have this physical on the same day so they've already cancelled the physical…in fairness that was three months notice they gave me on this physical being cancelled due to unforeseen circumstances. *Pause* It's not that unforeseen if you can let me know three months before which was my exact response to t them…It's not unforeseen it's foreseen three months away…They didn't tell me what the problem was so then it's just like 'we're not gonna tell you that simple honest answer'" (Dan)

He is frustrated both by the appointment that was cancelled in advance because of the GIC's failure to provide an explanation as well as the appointment that was cancelled on the morning of. This is also a problem with other health services. Flora discussed their experience of Children and Adolescent Mental Health Services as follows:

> "I started off there but I literally quit after three sessions because they would cancel on me. Like I'd get there and they would cancel my appointment then and there, or sort of say 'it's cancelled' and then I would cry and then the guy would come out and give me my appointment anyway"

The healthcare Flora was accessing here was not specifically gender related, but the issue of cancelled appointments was still prevalent and distressing.

Ticking Boxes

Another feature of these bureaucracies is the idea of ticking boxes. Having gatekeeping practices in place that are purely exercises in going through the motions. When Dan was at an appointment he saw as unnecessary he asked the doctor what the purpose of the appointment was and the doctor replied to "just basically tick boxes" (Dan). Another participant described her first appointment as follows,

> “It was an assessment by the senior and their old school psychiatrist who barked questions and it was more, it was a tick box exercise, yeah. And for those expecting psychotherapy it was roughly the opposite *laughter*. And I know people who think mental health services are there for your mental health therefore to expect some sort of caring, might be didactic but it would be caring, and what they got was the opposite *pause* you know basically it's the gatekeeping exercise of 'are you real?'” (Emily)

Emily is experiencing a disconnect between transness being labelled as a mental health issue, and thus gender services being connected to mental health services, and the care she actually received. She expected psychotherapy or at least a “caring” encounter but instead was met with having to tick the right boxes to prove her realness. Another participant, Ben, discussed being very aware of having to tick the boxes during his private gender services appointment to the point of, in his words, lying to make sure he ticked those boxes. When I asked him if he felt he had to say or imply that he wanted top and bottom surgery to access hormones he said:

> “I don't think anyone mentioned top surgery and bottom surgery and all that stuff but it was definitely like *pause* the, the vibe was the kind of thing, it was expected I think, although it wasn't really expressly said so I just went with that. I, I just kind of gauged what they were doing and it seemed like when I was being assessed that's what they were looking for, just ticking boxes. I think he was literally ticking boxes as I was going…so I just looked at that and I just thought ‘okay I'm just gonna’, you know, cause I didn't go in there thinking I'm gonna lie through my teeth…I kind of just got in there and I thought ‘ugh this environment is a little bit like intimidating I'm just gonna see how it goes’ and then that's what it was” (Ben)

Due to the person assessing him ticking off boxes, Ben omitted the fact that he does not identify as a binary man and does not want a linear, binary transition because he was worried that if he did not tick those boxes of binary and wanting to go through with a “complete transition” that he would be denied the testosterone he was seeking. Paul B. Preciado noted a similar feature of the French medical bureaucracy, that “in order to legally obtain a dose of synthetic testosterone, it is necessary to stop defining yourself as a woman” (2013, pg. 60). This was not something they were willing to do so they self-medicated instead. People knowing what the boxes are (or thinking they know what the boxes are) and having no other choice but to make sure they tick them to access the care they require reinforces to the bureaucracy that their boxes are accurate.

Having heard many stories similar to those the participants have relayed I arrived at my GP well prepared to tick the necessary boxes and jump through whatever hoops would be placed in front of me (another feature I discuss below). A friend who had gone through the process before sent me the list of questions, the literal boxes that the GP would have to fill out, so I could prepare my answers. I went into the appointment with my guard up but my GP was quite supportive as they had done this before with another patient at the practice. They had printed out the list of questions for the Charing Cross clinic but I corrected that I wanted to be referred to the Northampton clinic so they printed out that sheet (the one I had studied) and went down the line asking me each question. I answered them slowly but briefly so my GP could copy down my answers. All in all it took about ten to fifteen minutes. What struck me more than anything going through this process was how unnecessary it all felt. The questions asked were the same ones that are rehashed in the first appointment at the GIC so providing the information did not feel productive. It was essentially a self-referral by proxy. The only difference I experienced between say when I referred myself for physical therapy to this referral experience was who physically filled out the form. My GP merely copied my answers down word for word so their only function in this exchange is an authority given to them by the NHS to tick these boxes. An authority that is not extended to me as the trans person seeking access to the GIC. I have the authority to refer myself to the physiotherapist but not to the gender clinic (I address this further below).

Jumping Through Hoops

In our conversation, Dan described how he struggled to find out what hoops he had to jump through in the first place. His case is different from the “usual” NHS care path as he went on testosterone and had top surgery privately while on the waiting list for the GIC, so by the time he was seen he was only seeking lower surgery. He explained that at Charing Cross there is specific guidance on what the process entails and what appointments you need to have for what reasons in what order, but even after being seen at his clinic (Northampton) he remarked “I still didn't know what the hell I was doing” (Dan). He asked his psychiatrist at the clinic who told him another doctor would make it clear at his physical.

> “So I drive up for a physical, guy rocks up late which annoys me. Anyway we start talking, ‘is this your first appointment?’ I'm like *pause* ‘okay’. Then he tells me I don't need a um, I don't really need to have a physical. He goes ‘oh I don't know why they booked you in for a short appointment you need a much longer one for a physical’. He said ‘are you only here for this?’ and I was like ‘yup’. And he must have been able to tell by that point that I'd lost all interest in being there. Right now the only thing that he could do was give me the answers on what hoops I need to jump through, so I'm like ‘*I feel like a flea, tell me what hoop I need to jump through and I'll do it*’ and so then he turns around and he's like ‘oh well I suppose you don't really need it we normally do it as first before we get on testosterone’… so I'm just kinda like ‘well okay so why do I need to do it now’ and he goes ‘*just basically tick boxes*’ and he was like ‘but I don't think we need to do it’ blah blah blah” (Dan, my emphasis)

He felt that he was being rushed through the appointment which he later attributed to there being confusion around him having a referral for another mental health service and them thinking he was going to be leaving their care. Although he has resigned himself to having to jump through hoops, he is not happy about the process and he at least wants the hoops to be clearly laid out for him, so he is further annoyed when that is not the case. The clinic is failing to communicate to Dan what exactly he can expect and what is expected of him and they are attempting to shift the responsibility onto another service. Carey also described their experience of getting referred to the GIC in a similar way, remarking that "in Wales, they still have the hoop that you have to jump through where you you instead of just going to see your GP and getting referred to the gender clinic you go see your GP, then you go see a psychiatrist, and then they refer you to the gender clinic”. This extra hoop has also impacted George’s life. He is from Wales but told me that "the main reason why I moved to England is because in Wales they have no gender identity clinic”. Him and his partner want to move back to Wales but he does not want to jeopardize his place on the waiting list. In addition to delaying and complicating healthcare for trans people, some of these “hoops”, such has having to get two signatures for lower surgery, are also frustrating for the clinicians enforcing them, as I discussed in Chapter 2.

Shifting Responsibility

This feature of bureaucracy that some participants picked up on of shifting responsibility comes into play when overworked services appear loathe to take on patients that they see as already being under the care of another service. Adam, who was struggling with mental health issues not related to his gender, sought therapy to deal with those issues while he was on the waiting list for the GIC. His GP was encouraging him to wait to see the psychiatrist at the GIC[149] but he was insistent that he needed outside help and got on the wait list for Camden Mental Health Services. He explains his experience with this as follows:

> “I went in and spoke to someone from the Camden mental health team, and you know they did the same thing that basically this GP ended up doing which was, you know, they kept kicking the football back to…the gender clinic. 'Oh the gender clinic will have psychological services so why not wait until’, you know and they knew that what I needed in terms of that aspect of my mental health, what I needed was trauma therapy, and they were assuming that that was something that was gonna be on offer at the gender clinic. And I kept saying 'I really don't think that's the way it's set up from like what I've read about on their website I think it's just that you can get psychological, like you can get therapy for your gender issues like if you're having a hard time coming to terms with your gender you can get therapy for that but I don't think that they offer trauma therapy or any therapy that's not related to gender issues’. ‘Oh well wait and see' you know that type of thing” (Adam)

Adam ended up having what he described as a nervous breakdown and requiring emergency mental health services. Dan also sought the care of his local mental health team because, as he said, “if I'm gonna get problems sorted out then all good I've got a whole new body I actually wanna live, I wanna live without a whole load of mental problems afterwards” (Dan). Here he is framing the mental health services and the GIC as both essential but very different services. The GIC is helping him get his “whole new body” while the mental health services are helping him live free from “a whole load of mental problems” in that new body. When he got through to the local mental health

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[149] As I discussed in Chapter 2, the GICs have mental health professionals as part of their multidisciplinary teams, however they are not commissioned to offer therapy or any psychological support that is not related to gender and/or transition.

team, they tried to refer him to the GIC. He informed them he was already under the care of a GIC but they told him his problems were too gender related. Vincent highlights this very issue in their guidance for mental health providers:

> "It is vital that mental health practitioners do not refuse trans clients on the assumption that they are not qualified or equipped to address issues that could be (or could be related to) dysphoria. There is no reason why a mental health provider cannot work with a trans person to assist with mental health prior to (if sought), during, or after a medical transition process" (2018, pg. 75).

Even if Dan's mental health problems were related to gender, he should not have been refused mental healthcare on that basis. After being turned away from his local mental health team, he made an appointment to discuss these issues with the psychiatrist at the GIC but was told by them that his problems weren't "gender enough". Just like Adam he describes feeling desperate for someone to accept the responsibility of helping him, as he said, "all my problems are gender until I go to the gender identity clinic and then they're not gender enough…where in actual fact I just wish someone would acknowledge that all my problems are mine and I really don't want them to be problems anymore" (Dan).

A few things seem to be going on here. One is this bureaucratic instinct to shift responsibility to other services. Another facet that enables this shifting responsibility is the deep compartmentalization of the mental health services. This shifting responsibility is made possible by the highly specialized identity of the GICs, their existence allows for anyone questioning their gender to be separated from the more general mental health services. Additionally there seems to be a misunderstanding of what the other services do. An assumption that "you get this help elsewhere" when that's not necessarily the case as well as an assumption that people only have one "issue". In Adam's case the assumption was that all his issues were gender related and that he could get help for all his issues at the GIC when in fact he needed help from the GIC for transition related healthcare but also happened to have separate trauma issues and required additional support from mental health services. These misunderstandings, assumptions, and shifting responsibilities are resulting in trans people not receiving the care they need.

Forms

Another common feature of any bureaucracy is its paperwork. In the case of the NHS, the referral forms for different services can illuminate how those services are understood and what level of gatekeeping is at play. In the following sections I will look at the referral forms for the Northampton (Appendix D) and Charing Cross (Appendix E) GICs[150][151] alongside referral forms for Whittington Health Musculoskeletal Physiotherapy (Appendix F), Camden and Islington Mental Health Services (Appendix G), and NHS Wales "female breast reduction" (Appendix H).

Self-Referral

As I discussed above, my experience of filling out the GIC referral form with my GP felt like a self-referral by proxy. Comparing the form my GP and I collaborated to fill out to refer me to the Northampton GIC with the form I filled out to refer myself to physical therapy[152] about a year prior shows some interesting distinctions. The first major difference is that the GIC referral form is twelve pages while the physical therapy referral is only three. The first couple pages of the GIC referral form are directed at the GP, explaining the process, outlining the NHS best practice, and reminding them that "GPs must co-operate with GICs and gender specialists in the same way that you would co-operate with other specialists". This would be completely unnecessary in the physical therapy form as there has been a gatekeeper removed (the GP) so there is no need to provide these instructions to said gatekeeper. This is followed by a patient consent section which is also notably absent from the physical therapy form. It would seem that there is something considered more serious about being referred to the GIC as you do not even need to sign the physical therapy referral and can simply email the form in.

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[150] I selected these two as examples because these are the only two GICs used by the participants.

[151] See Vincent, 2018 for an in depth look at the referral process for all GICs as of late 2017.

[152] Whittington Health operates their adult Musculoskeletal Physiotherapy on a completely self-referral basis where patients can download the form online and return it via email, post, or in person without ever having to go through their GP. Other trusts and other physiotherapy networks operate in different ways so self-referral is not necessarily standard. This simply serves as one example of effective self-referral to a specialist service within the NHS that I have had personal experience with.

A positive feature of the GIC referral form is its awareness of gender and sex. While the physical therapy form only has “male” or “female” to check the GIC form asks for “Assigned Sex (at birth)” and leaves the space blank to write in which would allow intersex people to specify their sex in a more detailed way. The GIC form also asks for more biographic information that the physical therapy form does not require, specifically age and religion[153]. After the biographical information, both forms ask for a description of the reason for referral, with the GIC form specifically asking for a “detailed” description and allotting far more space for each question. While the physical therapy form asks a bit about employment and activity, which are specifically relevant to that type of issue, the GIC form asks for “Current Circumstances (Details of current living arrangements, on-going physical, social, financial concerns, support networks, relevant history, childhood, education, relationships, occupation)” which it is difficult to relate to the care the GIC will be providing. These differences in length, thoroughness, and types of questions asked highlight the additional gatekeeping practices the NHS bureaucracy has in place for gender services and how it might look different as a true self-referral process.

Mental Health Services

A potential explanation for the thorough assessment of “current circumstances” and mental health history and status in the GIC referral forms could be because the GIC is in some ways treated like a mental health services. However when comparing these GIC referral forms to the Camden and Islington Mental Health Assessment, both the Northampton and the Charing Cross GIC referral forms ask for more detailed mental health information than the referral to mental health services. The Charing Cross form even has a section for “forensic history”, something that was not deemed relevant to include in the mental health services form. Much like the “current circumstances” section on the Northampton form it is difficult to see the use of this section when providing people with transition related healthcare. Trans people are consistently being

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[153] Both forms ask for ethnicity but the physical therapy form specifically states that it is optional while the GIC form does not.

asked to provide more information and to go through a more stringent process to access their care than people seeking similar services that are not trans specific.

Breast Reduction

Surgery that is labelled cosmetic is generally not provided on the NHS, however there are a few exceptions. If someone can show that their breasts are too large and are causing them pain (and that they have tried and failed to use non-surgical interventions), someone can apply for funding for a breast reduction. As sociologist and gender scholar Diane Naugler explains in *Crossing the Cosmetic/Reconstructive Divide: The Instructive Situation of Breast Reduction Surgery*:

> “The pursuit of (government or insurance industry paid) breast reduction surgery in Canada, the United States, and Britain is currently acted out under the rubric of illness. As such, emotional and aesthetic concerns are seen as secondary to physical complaints” (2009, pg. 229)

Essentially one must prove that they are seeking this “cosmetic” procedure for non-cosmetic reasons. Even with this difficulty, the referral form is very brief and straight forward. There are no questions about the patient’s mental health, criminal history, or living situation. If a transmasculine person wants a complete breast reduction (double mastectomy) with the NHS, they have to provide all of this information, wait to access the GIC, then make it through the process of accessing top surgery[154]. Once again the trans specific healthcare is more difficult to access and the referral process is more invasive than the similar procedures that are targeted toward cis people. In this case, what trans people are seeking sits at the border of the reconstructive/cosmetic divide. Trans people cannot use physical complaints to access top surgery which would make it firmly reconstructive. They may have mental/emotional distress and/or aesthetic concerns, but as Naugler highlights those are not given as much weight. The very idea of a reconstructive/cosmetic divide itself “elides its own dependence on notions of normalcy and gendered embodiments” (Naugler, 2009, pg. 235). It is this idea of a normally gendered body with, in this case, the appropriate absence or presence of

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[154] J.R. Latham also addresses this dichotomy between breast reduction and double mastectomy in their 2017 article *Making and Treating Trans Problems: The Ontological Politics of Clinical Practices*.

breasts and the correct size of those breasts, which trans people are disrupting when accessing top surgery, hence the additional bureaucratic hurdles.

Bureaucracy as a Social Network

In *Intimate Distances: Fragments for a Phenomenology of Organ Transplantation*, Chilean biologist and philosopher Francisco Varela recounts the process of getting a liver transplant. They describe the bureaucracy that gave them a new liver as a "complex social network", a concept that translates onto the GIC system (2001, pg. 260). Like Varela's experience of the elaborate bureaucracy that gave them someone's liver, the GIC system too is a complicated web of different actors, agencies, and paperwork that one must be fairly adept to navigate. Entwined in this social network are GPs, GICs, psychiatrists, endocrinologists, surgeons, other care providers, receptionists, pharmaceutical manufacturers, the federal government, policy makers, trans people, and so on. Each play a role and interact with the other actors to make this system run and each can play a role in the ways it shifts and changes over time.

There are two distinct hierarchies within this social network, one between doctors and patients, and another between patients. In the doctor-patient relationship the doctor has the authority of their education and position as expert. Varela highlights this when discussing how they and many other liver transplant patients have asserted that they can feel their liver while doctors insist that that is impossible. There is a disagreement between the doctor's expertise and the patient's expertise as the person living through the experience. This relationship is even more complex in the GIC system as the patient often must be the expert, educating doctors to access the care they want. Furthermore they must be the expert on what the doctor's expertise is so they can line up with the doctor's knowledge in order to be accepted as trans and given the care they are seeking[155]. Between patients Varela acknowledges that they themselves are very privileged in terms of class, location, and even the time they live in to be able to access this treatment. These privileges are at play in trans healthcare as well. Those with greater financial resources can pay to "skip the queue" by going private and people living in certain parts of the country have easier access to GICs and GPs willing to refer

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[155] This strategy of selectively deploying personal narrative will be discussed in more detail in Chapter 6.

them to those GICs. People who wanted to transition even just a few years ago had a more difficult path than those going through the process today and waiting times for services differ between services and over time.

Time

Wait Times

A defining feature of transition related healthcare in the U.K. is waiting, or as one participant Emily called it, “marking time in the system”. This waiting primarily takes place on the waiting list for a GIC but it can also take the form of waiting for psychiatrist appointments, therapy, hormones, surgery, and waiting to be able to reach out to get the initial referral from the GP in the first place. This waiting can differ based on two key factors, financial resources and geographic location. If people have the financial resources they can go private which greatly shortens the wait time for whatever care they are trying to access. As Ruth Pearce observed when discussing trans temporalities, "the financial costs of private treatment and/or the possible risk of self-medication are typically regarded as preferable to the *uncertainty* of waiting" (2018, pg. 150, my emphasis). Each GIC also has a different wait time so depending on where someone lives and which GIC is closest to them they may wait different amounts of time for their appointments, although some people in England who are able to travel may try and get referred to a GIC farther away if they know it has a shorter wait time.

Waiting for Medical Care

In *Waiting for a Liver Transplant*, Brown et al. describe the changing emotions of people on the liver transplant list, starting with feeling blessed and happy to get past the first hurdle and get on the list followed by discouragement as time goes on and fear of surgery once they get closer (as well as guilt that someone will have to die for them to live). Many of the participants discussed a similar trajectory, feeling happy and excited to get on the GIC waiting list but disappointed upon realizing how long they would have to wait until the next step as well as fear of not being accepted as trans enough or being denied the care they are seeking after all that waiting. During this process of waiting, Brown et al. observed that everyone on the waiting list thought about time but in their own ways, “time is experienced both as 'moving very fast' and stretching out all at once” (2006, pg. 130). Time spent waiting is a liminal space distinct from their past before they were on the waiting list and separate from the future they are hoping for after they have finished waiting.

> “They are the people of the List. They are denizens of a strange land with dark terrain, where time speeds up and slows down in rhythm with the imaginatively felt signs of closeness or distance from transplantation, their own private *eschaton*[156]…time on waiting lists is a time apart from the narrative of their lives. Those waiting feel held up or on hold in a purgatory with its own clock...It is a time of utter subjectivity...Despite the initial sense of elation and gratitude that accompany being placed on the transplant list, in time, depression and emotional lability are common to the experience and arise out of a sense of frustration of other goals” (Brown et al., 2006, pg. 132)

The time spent in this liminal space, in this "passivity of patient hood”, always looking toward the future, takes a toll on people’s mental health and is exactly the type of waiting that the trans people I interviewed described experiencing as they waited/wait for months and even years to even begin to access transition related healthcare.

Waiting for Trans Healthcare

There are several episodes of waiting that someone transitioning may experience. Waiting for the courage to seek out a referral from one’s GP, waiting for the first GIC appointment, waiting to be approved for hormones, waiting for the prescription to come through, waiting for the physical changes of hormones, waiting to be approved for various surgeries, waiting for those surgeries, waiting to fully recover, etc., however I will primarily focus on waiting for one’s first GIC appointment as that is often the longest and most fraught wait. Many participants were surprised by how long that initial wait time was, both because they were not told explicitly how long the wait would be and because it was significantly longer than the eighteen weeks the NHS promises. Emily, who went through the referral process in England when the English care path still had tertiary care, described her experience as follows,

> “It was a six month wait or so before, because the mental health team were *long pause* I think it was longer than six months might have been eight months, it

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[156] Eschaton is the end of the world.

> was a long time. Basic problem was the mental health team had only one person they believed was competent to make a judgement on gender stuff and they were away on secondment or holiday or whatever else and that meant they were booked up" (Emily)

She ended up waiting longer than she expected because of limited staff and something as arbitrary as one employee being away. Adam was referred more recently so was able to get direct referral and explained his experience:

> "Unfortunately the waiting times for to access NHS treatments in England for gender therapy were just quite long and it took longer than anyone expected it was going to. Being referred in September of last year and they received the referral at the end of September and that's when the sort of clock starts ticking, and you know according to NHS guidelines it's supposed to be, you're supposed to be seen within eighteen weeks of once that clock starts ticking, so a little over four months maybe five months, and from the time that I was referred it took them six months to even notify me about when my appointment was gonna be and then my appointment ended up being ten months after. And the wait times when I was referred were three and a half/four months so it's been about twice as long, nearly three times as long as everybody expected it was gonna be" (Adam)

Adam is acutely aware of both the NHS guidelines for how long he should have waited as well as the GIC's published wait times when he was referred and he was still waiting far longer than he expected. He places the blame for these long wait times not on the NHS itself but on the government for not providing enough funding. As he sees it, "they're just trying to do the best that they can with what they've got so I can't fault them" (Adam). Carey explained how the waiting makes them feel "kind of crap":

> "I had to wait seven months for my…first appointment with the chronic pain management service and that was just a nightmare, and I know that this is gonna be longer than that for something that effects my life just as much if not more so it's frustrating. And it's frustrating not knowing how long the waiting list is right know like I've been looking at figures that are kind of from last year and that are approximations and I have no idea whether there's been a sudden spike at this point of people being referred so it's yeah I'm impatient. I like to know how long I'm gonna be waiting and yeah just not knowing and not knowing how long everything's gonna, you know this is the waiting time until my first appointment I have no idea how long after that it will be until I potentially am able to get top

> surgery so it could be like three years and I've already been living with this discomfort without having spoken to my doctor about it for three or four years so we're talking like the same length of time again potentially until I can feel comfortable in my body which I try not to think about too much because it makes me very sad and freaky outy" (Carey)

They have experienced waiting for healthcare before so they know a bit of what to expect and are experiencing stress both at the prospect of a long wait as well as not knowing how long the wait will be.

Navigating Unclear Wait Times

With several participants there was confusion around how long the wait list was and what kind of communication they should be receiving from the GICs. Many participants discussed calling or emailing their GIC to try and find out more information, often unsuccessfully. Carey was awaiting a confirmation letter from their GIC but actually found out they were on the waiting list from a different clinic. They went in for a routine blood test and was told by the nurse that the GIC had also requested their bloods. This was the first they had heard of being on the GIC's radar and at the time of our conversation they had still not received a letter, "I am still waiting for a letter from Charing Cross saying welcome to the waiting list, and maybe I won't get one I don't know if I'm…just wait for nine months and then get an appointment but my doctors know that I'm on the waiting list" (Carey).

Other participants knew about the long wait times and tried to navigate them. I was warned about them by my GP when I went to get my referral. I was told "well you know this won't be happening any time soon", that the wait times were very long, with a tone of discouragement as if they were saying "are you sure you want to bother?". I am also facing an unclear wait time for a hysterectomy because I do not want any other lower surgery. As I explained in Chapter 2, a hysterectomy without metoidioplasty or phalloplasty is not within the remit of the gender dysphoria pathway as it is currently commissioned so accessing that procedure on the NHS will be difficult if it not impossible. Not only will I be waiting an unknown amount of time but that wait may never end. Dan asked to be referred to the Northampton GIC because it had the shortest wait times at the time he was seeking his referral. His GP however accidentally sent the referral to Charing Cross so he got behind when the referral had to be changed. The stated waiting time came and went with no appointment and he called many times before eventually being told that he would be waiting an unknown amount of time but that it would be many months longer than he thought. After receiving this update he went private for his hormone therapy and later for top surgery to shorten the wait. Adam accessed private gender therapy while he was on the GIC waiting list. Carey, who lives in Wales which does not currently have a gender clinic, could have had a shorter time on the waiting list but they have a chronic illness which complicates their ability to navigate the system. They are originally from London and have an address there so in theory they could have registered at a GP practice in London and gotten referred directly to Charing Cross. However because they need consistent monitoring of their chronic illness, they need to be registered at a GP in Cardiff where they currently live and attend university. For this reason they had to go through the Welsh care path which still operates tertiary care, meaning they had to go first to their GP (which they did in October 2016), then get an appointment with a psychiatrist (February 2017) who referred them to the Charing Cross GIC. At the time of our conversation (April 2017) they had just found out they were on the waiting list so it took them an extra six months just to get to the point in the process that would have been the beginning if they had been able to go through the English care path. They are planning to see a private therapist while on the waiting list for the GIC.

Another participant, Flora, did not even bother with the NHS and went straight for private care. They explained their concern over long wait times as well as the idea that the waiting might be for nothing.

> “Just as long as I can remember I've heard terrible things about trans healthcare with the NHS and waiting lists and sort of the fact that they, stuff like they send you letters instead of emails and it just seemed like I would be waiting a very long time and I would be incredibly unhappy and sort of I guess I am privileged enough to be able to pay for private healthcare so I thought why wouldn't I… I worried that I'm just not binary enough…I was just really scared that I just wouldn't be believed so I could be on a waiting list for like two years and then sort of be turned away and yeah I just thought…to myself if testosterone turns out to be an absolutely terrible idea at least I haven't had to wait for two years to be on it” (Flora)

For Flora, waiting a long time was not even an option since they were able to go private. They did note however that wait times have gone up for private care too, they waited five months between their initial appointment and seeing the endocrinologist to confirm their testosterone prescription (although they had a bridging prescription during that time). On the contrary, another participant who went private described being shocked at how quickly he was able to get testosterone.

> “I just looked it up online. I don't I really, don't know how I found it, it was kind of like completely out of the blue. I had this impression that if you want to be on HRT it's gonna take forever and you have to wait and everything like that and I was just searching around one day and I just found it and it was kind of like too good to be true I didn't really believe it. And then I just went through that and it was it was pretty good actually you can have it very fast” (Ben)

In this case he knew about the long wait times for NHS care and was pleasantly surprised when he found out how quick private care could be.

In addition to the strategies of being aware of different wait times to get referred to the GIC with the shortest waiting list and going private, Carey describes a different perspective on potentially inadvertently “skipping the queue”.

> “I end up with a lot of like chest pain quite a lot and I'm always like I need to go and see [my GP] to make that this is the normal thing not something different, but every time that happens I'm like 'oh hm but if I, if I did have breast cancer maybe I could get a double mastectomy like sooner than I would through the the other services’. Which makes me feel like crap because I'm literally like 'huh hm maybe if I had cancer I could get this soon', that's not how normal people think. I have at least one other non-binary friend who has had the same thing happen, two other non-binary friends who have had the same thing happen, and it's like a real genuine fear as well I'm like 'oh my god what if I have cancer', but then I'm like ‘oh…I should be worried about this' and I am really worried about this and then I feel guilty for kind of almost wanting it…and then I just feel really fucked up so it would be nice to know definitively how-when it was gonna be *long pause* because the uncertainty is like not good for my ment-my mental health, is what it comes down to basically” (Carey)

They are experiencing a thought that if this terrible thing happened there is this way they could get around the waiting list, but that would be dangerous and scary in its own right and they feel guilty for even entertaining the idea. They also highlight again the issue of not knowing how long the queue is, that it is not only the waiting that is bad for their mental health but the not knowing how long the wait will be.

Attitudes Toward Waiting

Participants experiences of and attitudes toward waiting were not consistent but changed over time and with the situation. Ben who waited two months to get on testosterone privately, a wait he described as quite quick, hated waiting the twenty minutes that his Testogel would take to dry each day so he switched to an injectable form of testosterone. This type of short term waiting differs from the longer term waiting where life continues through the waiting process. Barbara Adam sees this type of waiting as being more difficult because of the commodification of time in contemporary society:

> “Today the idea that time is money is so deeply entrenched in the industrial way of life that no aspect of social existence is exempt from its practical expression. It is implicated when mothers rush to get the children dressed for school, when we opt for the fastest mode of transport, when we are obliged to wait in the doctor’s surgery” (2004, pg. 127)

Wasting time is equated to wasting money, or at least to wasting something valuable, so the time it takes Ben’s testosterone gel to dry is seen as wasted and therefore distressing in a way that waiting for the testosterone prescription while getting on with day to day life was not. Similarly experiences of long term waiting can change under different circumstances. Dan found that he initially thought he could wait for bottom surgery but that perspective changed. He explained,

> “especially before my top surgery where I was just like, I think at the minute it's not my priority, I'll just wait until they can grow me my own penis in a little petri dish and I'll have it implanted it's fine I can wait. And then of course time goes on and you have the top surgery and it's like ah I don't know if I can wait” (Dan)

Once he had hormones and top surgery, which for him were more urgent, his patience for bottom surgery dwindled.

Dan also described a difference between his understanding of what constitutes the waiting time and what the doctor at the GIC counted as waiting. This interaction happened when he had his second appointment at the GIC after going private for hormones and top surgery while on the waiting list. His GIC requires a minimum six month wait from assessment to getting top surgery but Dan did things quicker by going private.

> “first he told me that I had my chest surgery too soon and when I asked why and he said ‘well we like to make sure that people are pretty sound on and they know and they're not gonna regret it’ and I went ‘well if I regretted it it wouldn't fall on you guys anyway it would fall on them’ and the fact is I already waited you know even if we said from when I was an adult that's still 16 years to actually do any of this stuff” (Dan)

For Dan, he has been waiting his entire adult life if not longer for these hormones and surgeries, he has been marking time outside of the system. The doctor only recognizes time marked in the system. Your waiting does not count until you enter the official queue. Emily describes her experience with a doctor at a different GIC who was also hyper aware of the official queue. When I asked her if there was anything else that she was asking the GIC for that they were not willing to offer she replied:

> “Facial surgery, and they just said it ain’t, that ain’t happening. And I said this to [the doctor] actually I'm prepared to be a test case and…he was like ‘oh we've already got test cases’ and he just wanted me off the books because they're having a lot more people coming in…who knows what happened to all those patients who fell at one of the hurdles on the way there you know where they're expected to wait for a year or they've got a GP that isn’t helpful or they've got you know” (Emily)

Her experience of waiting was not only at the beginning, waiting to access the system, but also waiting within the system for something she would never receive. Once they had determined her transition was finished, she was discharged to make room for the next person on the waiting list. She also recognizes that not everyone will make it on or through that waiting list.

What Makes Waiting Easier?

Some waits are more difficult than others. Of course the length of the wait is a significant factor but there are other elements that can make the wait seem more or less difficult. From a non-healthcare perspective, business management expert David H. Maister lays out some of these factors as they are relevant to a modern, Western context in *The Psychology of Waiting Lines*. One of these principles is that people who are waiting “want to get started” (2005, pg. 3). They want confirmation that they have not been forgotten, that it is known that they are waiting. We can see this with Carey’s waiting for a letter saying “welcome to the waiting list”, they want official confirmation that the waiting process has started. This may also impact people’s experience of waiting outside versus inside the system. The wait to get in the door might be more difficult in this way than all the subsequent waits for services once inside the GIC system. Another principle that has come up frequently is that "uncertain waits are longer than known, finite waits” (Maister, 2005, pg. 5). I found that participants were keeping abreast of the estimated GIC wait times and Carey specifically expressed that not knowing how long the wait was going to be made it worse, a sentiment I share. The Royal College of Psychiatrists has also recognized how distressing unknown waits can be. Their position is as follows:

> “As a matter of good practice, service providers should take all reasonable steps to provide the patient with a realistic understanding of the time scales involved. Patients should have confidence that their treatment will progress in the agreed time scale. Service providers should also continually seek ways to help guarantee deadlines” (2013, pg. 18).

Finally, Maister asserts that “solo waits are longer than group waits” (2005, pg. 8). While this sort of long term waiting takes place in the background of one’s day to day life, the communities that trans people create and seek out, such as the online support groups, can make the waiting process far less lonely[157].

Taking Time

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[157] I discuss these support networks in more detail in the next chapter.

In her 2017 article *Taking (My) Time: Temporality in Transition, Queer Delays and Being (in the) Present*, sociologist and trans activist Atalia Israeli-Nevo takes a different look at waiting. She uses autobiographical narrative to understand taking time as a method of creating trans identity in a way that is mindful and purposeful. She explains her experience as follows,

> “Everywhere around me I felt enormous pressure either to forfeit this ‘trans escapade,’ or to ‘go on with it.’ The cis people around me were puzzled, anxious and sometimes angry with the fact that I demanded to be addressed with female pronouns and considered a woman without (at least seemingly) making any efforts to pass as a woman, except for wearing dresses and skirts. On the other hand, a lot of trans people were puzzled as well, and decided that the fact that I did not immediately choose to take hormones and pursue top and bottom surgery made me genderqueer, and were sometimes baffled by the fact that I dared to call myself a transwoman.” (Israeli-Nevo, 2017, pg. 38)

She chooses to take her time with her transition, carefully considering each potential step and thus resisting expectations of passing and of a quick and linear transition path. With the current NHS wait times, this taking time could even occur while “marking time in the system”. I was advised (and have advised others in turn) to get referred to the GIC as quickly as possible and figure out what, if anything, you want from them in the years you will be waiting anyway. This sort of efficient waiting is not necessarily in the spirit of “taking one’s time”, but in a system where one could carefully consider their next step, come to a decision, and then have to wait years to access that step, it makes sense. Israeli-Nevo recognizes that taking this time is a privilege she has, that she is safer as a white woman whereas a trans woman of color may have to rush to pass for her own safety. There is also a class consideration here, that while she is choosing to take her time for other trans people that choice is made for them due to not being able to afford a speedy transition. However as someone who is able to make that choice she finds taking her time to be a grounding experience, anchoring her in the present rather than in some longed for future.

> "As trans subjects in this transphobic world, we are encouraged and forced into a position of not being present. We are dissociated from our bodies, our loved ones, and our general environment. This dissociation throws us into a far future

> in which we are safe after we have passed and found a bodily and social home. However, this future is imagined and unreachable, resulting in us being out of time.” (Israeli-Nevo, 2017, pg. 38)

Refusing to root one’s life and one’s transition in a future and instead taking one’s time and staying in the present is a radical reclamation of time for the trans people who are able to do so.

Space

Waiting Rooms

In contrast to the long term waits to access services there are also short term waits on the day of an appointment or procedure. This type of waiting has a unique arena, the waiting room. The first time I went to a GIC, accompanying a friend to his Northampton appointment, I was surprised by how it was not separate or really demarcated in any way. We were told by reception which floor to go to and upon entering the double doors at the top of the staircase I (and my friend told me later he as well) knew we were in the right place. It is just a part of the mental health area of a hospital in a corridor seemingly many people walk though, indeed on one visit I sat next to an older person for some time before they realized they were in the wrong place. My friend and I however recognized it as a trans space immediately without any signage by recognizing fellow trans people in the seating area, one of whom recognized us in turn and gave us a nod.

Emily described the waiting room as the physical manifestation of the waiting list, which helped her contextualize her being discharged.

> “I remember when at that particular appointment and the one previous the waiting room was completely full you know I mean standing up. There were no seats for people, everyone, you had people standing you know filling the space and it was like something's got to give. And yes they cleared their books of the ones that he considered to be less dysphoric and were coping in society, felt brutal obviously but hey” (Emily)

She also detailed the atmosphere of that waiting room and other waiting rooms where groups of trans people wait for healthcare.

> “I know that, that I could be waiting for an appointment at Charing Cross and instantly things could turn into a little social event with chatting and talking about experiences and things, but that was never encouraged you know cause it's a hospital waiting room. I mean it's obviously you know comfy chairs and all that but it's still a hospital waiting room. And when that started to happen that's how CliniQ is…they encouraged it and they've got greeters now who where people are feeling like too nervous to join in where a greeter will sit and quietly talk to them one to one and then introduce them into a social atmosphere so some people come just to sit in reception there” (Emily)

These spaces defy the expectation of a hospital waiting room. Where one might expect a quiet, staid atmosphere there is laughter and socializing. They are transformed into spaces to meet new friends, catch up with people you know, and offer and receive support from people going through a similar experience.

This contrasts with Flora’s experience of getting private care. For them the lack of a concrete physical space was off-putting. For one they felt that not having the whole practice in one office impacted productivity.

> “I don't know who the secretary is…but, they don't have offices. I think he probably goes to a cafe to do his, you know emails…also from [his] Twitter once I saw, they were in a pub and it was like 'secretary meeting' or something and I was like right…so this is your business. Do you know what I mean like, so I just I on the one hand I'm sort of like it's humorous but then on the other hand I'm like so this is why you take forever to reply to my emails.” (Flora)

They also noted that the rented office space they went to for appointments lacked the specific identity and atmosphere that Emily described above, noting that “there are just random people in the waiting room like there was a child in there” (Flora). In this type of more temporary and partial space an identity and sense of community is unable to take hold. This is especially true when there is no waiting room at all. Ben sought private healthcare through a remote service which he found to be quick and efficient but impersonal, remarking that “everything is kind of like done online so you're always talking to sort of a faceless person, you don't really know who they are”. He, like Flora’s experience with their private service, also noted that it could be difficult to get ahold of staff and that their phone line was often busy and he couldn’t get through.

Anti-Trans Architecture

In *Transgender Architectonics: The Shape of Change in Modernist Space* Lucas Crawford discusses the ways in which transgender and architecture are inherently related. Architecture is gendered (and gendering) and transgender is spatial, they argue, “space and self are never so distinct” (Crawford, 2015, pg. 4). Space can help construct and support identity, but often times architecture, or specific spaces, are in direct conflict with transness and trans people:

> “trans women are routinely barred from crisis shelters; many of us lack of a place to properly eliminate waste in public; the public sphere itself is a series of architectures that sometimes seem designed to keep others vigilant in their surveillance of our bodies.” (Crawford, 2015, pg. 19)

Feminist scholar Sally Munt experienced this as a lesbian living first in Brighton which they describe as having “constructed my lesbian identity” and later in Nottingham which was hostile to them particularly as a butch lesbian (1995, pg. 115). Here space, understood on quite a large scale as entire cities, has the power to entirely construct, confirm, and support or to restrict and suppress a queer identity.

This ability of space to make or break identity can also be understood on a much (spatially) smaller scale. Bathrooms in particular are an obvious site of clashing between transness and physical space. To understand this clashing, Crawford explores the bathroom of the Brasserie restaurant designed by the firm DS+R. They argue throughout their book that a key gendered element to space is that architecture, structure, and exteriors are coded as masculine whereas décor and interiors are coded as feminine. Therefore the latter is dismissed as frivolous and not respected the way that architecture or other forms of art are. As Crawford explains:

> “The abjection of décor in modernist architecture finds a literal analogue in transgender’s abjection from contemporary public washrooms: we are often regarded as figures of bodily excess or dishonest adornment ourselves.” (2015, pg. 47)

In the realm of humanity, cis bodies are the architecture and a trans experience is the décor. Cis bodies are the necessary building blocks of the human experience and transness the frivolous décor of (assumed) bodily alterations and gendered expressions. In analyzing the particular space of the Brasserie Crawford notes:

> "DS+R have shown us precisely why washroom rhetoric and campaigns are *so* relevant and sensible at the current moment, at a time when the fictional 'pure' functionality of unadorned architecture still passes as every bit as normal and harmless as the normative, straight, white, able, and middle-class male body passes as unadorned or unconstructed." (2015, pg. 62, original emphasis)

Through understanding this connection between transness and architecture emerges a deeper understanding about how trans people and trans bodies are understood in society.

In addition to representing a broader framework of transness, bathrooms also play a crucial role in creating and maintaining gender. It is one of the very few places that, at least adults, are consistently segregated by gender in a Euro-American context. Thus it is a point of stress for many trans people and has become a legal battleground for the right for trans people to participate in public life. While often a difficult decision based on personal safety, choosing which bathroom to go into can be a radical pronouncement of one's identity and everyone in that restroom is participating in either reifying or rejecting the gendered assertions of the other occupants. One participant George echoes this when he talks about how accepting the school he works in has been of his gender identity in exactly these terms; he quotes his boss as saying, "okay you can only take the boys to the toilet and you can use the men's toilet and you are a man". This practice adds to the gender archive outlined in the introduction, "we are not observers or pre-gendered visitors to washrooms; we too are archives of gender affect, and each washroom we visit becomes a part of that archive" (Crawford, 2015, pg. 63). These visits to the bathroom, whether challenged or unchallenged, make up the gender experience of any visitor, trans or cis.

I see this idea of interactions with certain spaces as gender archival practice as logically extending to the more purposeful acts of doing gender; interactions with the

GIC, GP surgery, hospitals, pharmacies, etc. By merely showing up to these places in the capacity that a trans person does, seeking transition related healthcare, is not only adding to the archive of that person's gender identity but of their gender history. When Adam describes himself as a man with a "trans history", he is explaining that not only has his gender been archived and continues to be archived as male, but that this archive has been/is being curated in a certain way, in a trans way. The difference between Adam and a cis man then is not gender identity, but how they have archived their gender. Adam has taken extra steps that a cis man would not have to take, going to his GP to get a referral, visiting the GIC, navigating through the offices of the different gatekeepers at the GIC, continuing to go to the pharmacy to obtain his testosterone and estrogen blockers, going to CliniQ once a month to have his estrogen blockers administered, and eventually going to hospitals to have transition related surgeries. All of this is part of the process of archiving transness, of archiving not just gender but trans gender.

My experience of going into public restrooms is a consistently fraught part of curating my gender archive. Going into a gender neutral restroom is thrilling precisely because it is an experience that aligns with my existing gender archive. When no such restroom is available and I have to choose between a men's or a women's space, there is tension. Should I abandon the carefully curated project of archiving a comfortably masculine gender to go into the women's restroom where I will likely be safer? In that space I am often (although certainly not always) affirmed by the other participants but rejected by myself. In the men's restroom I am often (although certainly not always) rejected by the other participants but experience less cognitive dissonance with my existing gender archive. The purposeful acts of gender archive have, for me, been a much more positive experience. Going to my GP to get a referral to the GIC was a thoroughly affirming experience in which the two of us both contributed to my (trans)gender archive. I reified my non-binary gender and trans history by making and showing up to that appointment and going through the hoops of accessing a referral. My GP made unique contributions to my gender archive by not knowing "which way I was going" (basically they did not know if I was AFAB or AMAB) which affirmed that I am seen as at least somewhat gender non-conforming. By posing the questions on the form to me they also caused me to decide on a narrative of my gender that I will use to access transition related healthcare. This experience at my GPs, while a frustrating interaction with bureaucracy, also contributed positively to my (trans)gender archive both in reifying my non-binary gender but also because I have now experienced something which many other trans people have had to experience, reifying my trans history.

Axes of Power

What all of these elements have in common is that they enact power over trans people in a way that can jeopardize their health. With the complex medical bureaucracy there are many hurdles at which someone could fall before seeking transition related healthcare. In addition to that bureaucracy, other state bureaucracies (such as marriage or obtaining a Gender Recognition Certificate) are damaging in the way they take power for gender identification away from trans people and consistently erase gender diversity. Time is manipulated with inordinately long wait times for gender services in the NHS, although some people take that power back by choosing to take their time and/or by paying to go private and shorten their wait time if they are able to. There are also spaces, notably bathrooms, which can be fraught for trans people to exist in but also a reclamation of space in the way trans waiting rooms are constructed by their inhabitants. Throughout this chapter it is clear that the story of trans health in the U.K. is not as simple as one of succumbing to the whims of powerful state and medical entities. This understanding of how trans people are subsumed under these power structures is continuously challenged by the ways in which they resist and overcome the barriers these structures put in place. These strategies for overcoming barriers are addressed in the following final chapter.

Chapter 6: Pedagogy and TransLiteracy

"The Internet provided a vital catalyst for the
trans social movement to grow and change,
as a formerly largely invisible and geographically
dispersed population was empowered to come
together and organise on an unprecedented scale."
(Pearce, 2018, pg. 39)

"Like everybody's on YouTube and
everybody's trans *chuckle*." (Ben)

In this final chapter I respond to the previous two chapters outlining barriers to trans health by discussing how those barriers are sometimes overcome[158]. This chapter is largely descriptive of a specific moment in time and space[159], but this description is valuable in answering the second question of the dissertation: when they are able to at all, how do trans people overcome barriers to accessing quality healthcare? Firstly I identify what trans people need to learn in order to access quality healthcare within a system ill-equipped to serve them. I especially highlight the strategic use of personal narrative but there are a myriad of things that make up these trans specific knowledges, the amalgamation of which I call TransLiteracy. Secondly I look at how trans knowledges are disseminated and what makes this dissemination effective. I understand this system of distributing knowledge as a form of pedagogy, one that is not based in any particular institution but is rather a tool used widely by trans communities to improve health outcomes. The two key features of this type of pedagogy that I identify are that it is decentralized and social. Both aspects are important in ensuring that helpful information is disseminated broadly, and contextualized, which can improve trans health through increasing access to quality healthcare and through building social

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[158] This is just one possible way of overcoming barriers. Of course there are other ways and some people face barriers which they never overcome. Additionally, it is possible that accessing information in this way could create barriers, which I discuss below referencing Ruth Pearce's work on negative discourses.

[159] Namely the U.K., mostly London, between 2016 and 2018.

bonds. This discussion supports previous work by Israeli-Nevo, Spade, Ponse, Pearce, Raun, Andrews, Xhao et al., and Duguay and extends that of Latham and Poster.

Pedagogy

Many trans people become quite adept at educating themselves, care providers, and others within their communities. When it comes to healthcare, usually the medical care providers are the ones educating their patients but that role is often reversed for trans people who have to educate medical care providers and gatekeepers on medical practice and policy. Trans people must also, crucially, learn to deploy personal narrative in order to access healthcare. In order for this education to take place the trans person must first acquire the knowledge themselves which in turn requires them to know where and how to look for such knowledge. This education happens through community relationships which help trans people learn to advocate for themselves in healthcare and other settings. Currently a large portion of this education takes place online, so the social internet[160] plays a crucial role in the building of these communities and the dissemination of this knowledge. I argue that trans in its current form would not exist without the internet specifically because of this community education. These social and decentralized methods of knowledge sharing form an alternative model of pedagogy within trans communities, one that is crucial for trans people seeking to access quality healthcare.

The Material: TransLiteracy

There are certain things trans people have to know and skills they must acquire in order to navigate their healthcare, not to mention the wider world. Based on my own experience seeking this information, existing in trans communities where this information is being requested and/or shared, and the literature and experiences of the participants I will outline in the sections below, there are several important categories of knowledge. For altering gender presentation people may seek help on ways to cut and style hair, how to tuck, pack, or pad, safe binding practices, how to apply makeup, and

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[160] The portion of the internet where users interact with each other (a part of Web 2.0). In this chapter I will be primarily referring to YouTube, Facebook, Twitter, and Instagram although this is not to say there is not important community building and education happening on other platforms.

advice on styles and brands of clothing. When looking into surgical options they may ask for pictures of people's results as well as guidance on which surgeries and surgical methods to seek out, which surgeons and hospitals are best for what they want, how to get time off work, how to get funding for these procedures, help quitting smoking or losing weight to prepare for surgery, tips for healing, and how to minimize or cover surgery scars. If they are just starting to come out and socially transition, trans people may look for advice on coming out in different areas of their life such as to parents, siblings, extended family, work, school, partners, children etc., specifically regarding things like what to say, when the best time is to do it, and what to do if the person or institution reacts negatively. They may also require information about how to legally change their name, how to change their gender marker and get new government documents, and how to navigate various bureaucracies including the process for obtaining a Gender Recognition Certificate (GRC). If they are considering hormones they might want to know what changes they can expect from hormones and in what timeframe they can expect those changes, the benefits and challenges of different hormone delivery options, how to get blood work done, how to read the blood work results, what healthy hormone levels are, and even connections to buy hormones or injecting supplies[161]. In terms of more generally accessing transition related healthcare this would include knowing the respective wait times for different GICs and/or private providers as well as other factors to help choose the best one to be referred to, the benefits and drawbacks of going private versus going through the NHS, how to find which GP/surgery in the area will give a referral to the GIC, how to approach and in some cases convince the GP to give a GIC referral, coping mechanisms to employ during long wait times, how to access funding, what is on offer from the GICs or private providers, and how to deploy personal narrative to get certain things from a given provider. This knowledge also extends to general NHS policies, for example both Adam and Dan referenced the policy of an 18 week minimum wait for specialist services.

With healthcare that is not explicitly transition related, questions could be about how to maintain fertility, what health screenings are needed for different bodies, how to

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[161] Many people who are taking hormones self-inject at home, so they need to purchase the correct gauge needles and other supplies such as alcohol pads and a sharps container.

access those screenings, and tips for looking after mental health and seeking therapy or other mental health services. This extensive list is merely scratching the surface. For every one of the many ways a trans person's life is complicated by their transnesss, for every healthcare interaction they have, and for every healthcare decision they have to make, there is a resource of trans people who have either gone before and can thus offer their advice based on personal experience or at the very least can provide support and solidarity. This resource can be accessed in numerous ways which I will discuss below. This is not to say that personal experience is the only mode of knowledge valued: classifications of expertise that are important in the offline world are certainly recreated in these online spaces. For example, when someone asks a legal question in one of the online support groups I belong to, members always tag the lawyers in the group who can in some cases give both their personal experience and professional legal expertise. In this case, having a diversity of experiences both as trans people and as experts in other fields increases the knowledges available to teach and learn. This collective community experience forms the curriculum and participants can alternately act as the educator or knowledge distributor and as the student or knowledge seeker.

Deploying Personal Narrative

Of all the information and skills listed above, perhaps the most important aspect of TransLiteracy that people learn through this alternative pedagogy is how to construct a personal narrative. In her piece *Taking (My) Time: Temporality in Transition, Queer Delays and Being (in the) Present*, Atalia Israeli-Nevo discusses constructing trans time through narrative. In "[examining] the practice of being/making/creating/developing trans identity through the notion of 'taking one's time'", she challenges preexisting narratives that call for an instantaneous, or at least quick, transition (2017, pg. 35). She consciously took her time developing her trans identity and thus time itself became a part of her narrative. In this way narrative can be a site where trans people reclaim agency and resist a more limited definition of trans experience. Narrative can also be crucial for creating a positive interaction with medical systems, where both patients and medical professionals (co)construct narratives that connect the dots between the person the patient was/is before, the medical crisis or encounter, and the person they are/will become (see Mattingly, 1994 on therapeutic emplotment and Huss-Ashmore, 2000 on therapeutic narrative). Collaborating to produce these narratives are some of the sites of intra-action that I outlined in Chapter 3. Furthermore, the act of constructing this narrative can contribute to one’s gender archive as I discussed in the previous chapter.

Penis=?

When speaking about transmasculine people, J.R. Latham (2016) unpacks how male as a sex is created and understood through narrative. Trans men are frequently challenging heteronormative narratives such as the idea that they should only be attracted to cis women, that they should have no sex before bottom surgery, that they should enjoy sex after surgery, and even that they should have bottom surgery at all. When understanding the trans penis (or your own penis as a trans person), Latham explains that language is crucial and is constructed in relation to the self and in collaboration with sexual partners, thus “materialising a ‘male sex organ’ via translating one object into another, both narratively and practically” (2016, pg. 148). I understand this ept through the equation penis = the physical phallus + narrative[162]. In this equation, a penis could be the result of phalloplasty or metoidioplasty, what is usually referred to as a clitoris, a strap-on, a packer, etc. (phallus + narrative) and what is usually referred to as a penis need not actually be a penis (phallus - narrative)[163]. Only some of these narrative constructions require the collaboration of medical care providers. This narrative construction can also be used in conjunction with incorporating and disincorporating practices (such as packing and tucking respectively), as I highlighted in Chapter 3.

Accessing Care

While narrative can be used more personally, as in the case of phallus +/- narrative, to benefit the construction of the self, many trans people must also learn how

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[162] While Latham and I are specifically discussing trans penises here, the equation can apply to cis men as well, many of whom have the added benefit of others confirming their narrative understanding of their normative penis throughout their lives.

[163] Although there are certainly trans people who have what is usually referred to as a penis for whom that penis is part of their identity construction and therefore they fall into the phallus + narrative category.

to deploy personal narrative to access care and services. For example Ben who presented a carefully constructed narrative in order to access transition related healthcare:

> “I lied to be honest, I completely lied and just said all of the things that I knew they wanted me to say and then that's how I did it because I knew that I wanted testosterone and that was the most effective way to get testosterone. If I was gonna start telling the truth about every little thing that's gonna be more of a block so I just kind of went for what I wanted…I left a lot of stuff rather than actually lie, but left out the part that my dad is not supportive because one of my friends was held back quite a lot because his parents weren't supportive. They wanted to get like all of this information about his parents and stuff even though he was over 18… and then I omitted pretty much everything about being sort of non-binary or anything like that. I didn't want to give them the impression that I was like wishy-washy, not that that's what that is but I think that's what people think that it is you know? So I just pretended that I just 100% knew from when I was like one or something”. (Ben)

When presenting to a GP, GIC, or private gender specialist in order to access transition related healthcare trans people have learned what care providers are looking for, or what boxes they have to tick as was discussed in the previous chapter. This is part of what Dean Spade calls “the long-standing practice amongst gender variant people of strategically deploying medically-approved narratives in order to obtain body-alteration goals” (2000/2006, pg. 16). Spade harkens back to the story of Agnes who in 1958 presented to doctors in Los Angeles as an intersex person who had female secondary sexual characteristics but a penis and scrotum which were removed with surgery. Agnes later revealed that those female secondary sexual characteristics had been the result of self-medicating with estrogen since age twelve and not an intersex variation. In the U.K. in the 1950s Roberta Cowell presented similarly to doctors as intersex in order to access treatment[164]. At that time the only way to access transition related healthcare was if the bodily changes were presented as fixing a biological "condition" rather than fulfilling the patient's desire for a bodily alteration.

While trans people no longer have to present as intersex to access hormones and surgeries, there are still medical understandings of what a trans person is that they can choose to either align themselves with or to reject at the risk of not being able to access the care they are seeking. When the first gender clinics in the U.S. started seeing patients they were using Harry Benjamin's 1966 book *The Transsexual Phenomenon* as a reference for how to diagnose and treat trans people. They found that the patients at their clinics matched up perfectly with Benjamin's criteria.

> "it took a surprisingly long time — several years — for the researchers to realize that the reason the candidates' behavioral profiles matched Benjamin's so well was that the candidates, too, had read Benjamin's book, which was passed from hand to hand within the transsexual community, and they were only too happy to provide the behavior that led to acceptance for surgery." (Stone, 1991/2006, pg. 228)

Before the internet these peer networks shared knowledge on how to access surgery by learning the criteria from the same source the medical care providers were and showing them what they expected to see. However Spade problematizes the idea that trans people are "only too happy" to conform to expectations to access care. They note:

> "Personal narrative is always strategically employed. It is always mediated through cultural understandings, through ideology. It is always a function of selective memory and narration. Have I learned that I should lie to obtain surgery, as others have before me? Does that lesson require an acceptance that I cannot successfully advocate on behalf of a different approach to my desire for transformation?" (Spade, 2000/2006, pg. 328)

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[164] Cowell maintained that she was intersex in her autobiography (Cowell, 1954) so she may have been intersex and trans or intersex with a trans experience/history. However, as presenting as intersex was the only way she could have accessed transition related healthcare it is also possible that she was deploying a similar strategy to Agnes.

Spade has learned how to strategically craft and deploy narrative to access care but they are questioning whether or not they want to use that knowledge or if they would rather challenge those assumptions and advocate for themselves in another way. These conversations continue to happen within trans communities, including advice on how to access non-binary and non-linear transitions, but today they are primarily happening online as I will discuss below.

Identifying Allies

Something trans people have to be constantly aware of is how the people around them are reacting to or will react to their transness. This means it is crucial to be able to identify allies, or people who will be supportive and positive about one's transness. At school, work, within the family, in online interactions, while dating, making friends, and even in public amongst strangers, trans people will look for red flags (such as using a transphobic slur, purposefully misgendering other trans people, even homophobia) and ask indirect questions about gender diversity or trans inclusivity to measure their response. Of course if the person feels safe to do so they may also come out to the person directly and gauge their response from there.

Finding Community

In addition to being able to identify allies, trans people may also want to be able to identify other trans people. While they are not foolproof, there are certain ways trans people have of recognizing fellow trans people in public which can be useful for embarking on community building. Barbara Ponse found that this was the case with closeted lesbians in the 1970s being able to identify each other without outing themselves.

> “A standard feature of gay lore is that ‘it takes one to know one.’ It seems that this is not attributable to any mystical sixth sense but rather to a sensitivity-honed by the experience of passing-to the subtleties of various cues.” (1976, pg. 320)

The specific things they were picking up on included:

> “The failure to say certain things—for example, to specify the gender of an individual referred to in a conversation—to be secretive about one’s personal life, to express a lack of interest in males, to never having been married, to have a roommate, and to fail to present a male companion at appropriate times can start the speculative ball rolling on the part of a gay woman that another woman may, indeed, herself be gay.” (1976, pg. 320)

Ponse found that once these lesbians had a hunch that someone was gay, they would tread carefully, testing their hypothesis. They would do this by “dropping pins”, or mentioning things that would have special meaning to a gay person and judging their reaction. Additionally, “[a]n audience to whom a gay identity is to be revealed might be sounded about their attitudes toward gay people or toward minorities in general” (1976, pg. 331). These strategies allowed the women to not out themselves directly and could happen in front of straight people without them realizing.

In the case of trans people, if someone uses certain terminology, is wearing certain articles such as a pronoun badge or something with the trans flag, or reveals certain details about their life it can indicate to someone else in the know that this person may also be trans. All of these signals can be given in online spaces as well, such as through the terminology used and details shared in posted content, listing pronouns in profiles, and posting or sharing trans related images or content. I personally frequently wear a pronoun badge, am openly trans in my social media profiles, and disclose that I am trans to other people in hopes that they feel comfortable disclosing to me and we can connect. In any public situation, it can be comforting and feel safer to identify if there is another trans person around. In social situations, identifying other trans people is how you build community or get connected with existing communities of similar people, which is positive for people’s mental health and allows for the kind of education that helps them access healthcare.

Trans Dialect

An important facet in community building is having a shared language. Within the English speaking population in the U.K. that I am a part of and conducted research with, trans people have a shorthand consisting of abbreviations and slang terms that allow us to quickly, easily, and sometimes covertly, communicate with each other[165]. This language is learned through the same online and offline methods as healthcare knowledge. It consists of a literacy around discussing gender and a shorthand for celebrating, connecting, educating, and grieving. One celebratory example is people marking alternate “birthdays”. For some people this birthday is the day they came out as trans, for some it is the day they started hormones, and for others this is the day that they had an important surgery or the last procedure they will be seeking for their transition. This is significant because the person is raising the importance of these moments in their gender history to the level of the day they came into existence. In some cases it is replacing that day, as if to say “this is the day I was *really* born”. If they are celebrating beginning hormones, many transmasculine people refer to this as their “T-day”, or the day they started T (testosterone). While this is not explicitly using the language of birthdays, it mirrors the common abbreviation of “B-day” for birthday, so saying something like “happy T-day” evokes a similar type of celebration. Here people are explicitly bringing attention to the fact that it is an alternate birthday by saying “happy T-day” rather than simple “happy birthday”, but that is not necessarily always the case.

Preparing for the Worst

Much of what constitutes TransLiteracy and indeed a significant portion of this dissertation, focuses on negative experiences and “worst-case scenarios”. In *Understanding Trans Health: Discourse, Power and Possibility*, Ruth Pearce discusses how this negativity operates, particularly when information is distributed online. She admits that “[the] discourse of difficulty perpetuates fear and concern amongst patients early in the transition process” but that the upside of this is that it “also enables them to prepare" (2018, pg. 144). Stories of mistreatment in healthcare services generally and gender services specifically can be scary, particularly for someone just beginning to understand their relationship to gender and/or without a strong trans network. Ben

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[165] While I do define some basic trans terminology throughout this dissertation, a full linguistic analysis would be beyond the scope of this dissertation. A body of work as extensive as Paul Baker’s (2002) writing on Polari (British slang used by gay people in the mid 20th Century) could be written about contemporary trans communication.

demonstrated this in our conversation when he commented, “when you're dealing with lots of different healthcare people you have to be careful where you tread, you don't know who's good and who's not so you have to kind of air on the side of caution really”. Carey described a similar feeling as well:

> “when I've been doing kind of research and reading about other people's experiences you know it might be that for every ten experiences that are good there's one experience that's bad but the bad one is gonna stick out more so I'm gonna be like 'oh one person four years ago had a bad experience trying to access gender treatment in Wales, it's gonna be terrible'”.

Ingrid completely avoided the GIC system because of the negative experiences of others:

> “I didn't want to go through [the GIC] unless I absolutely had to you know. I knew a couple of other girls who had been through them and they kept talking about how badly they'd been bullied by the the staff there, and because I was, you know, reasonably well off I thought 'well let's go private'”.

In Ingrid’s case these experiences were directly from people she knows but Carey’s research was mostly done online where stories are often undated and can be presented as current possibilities even if they occurred in the past. When things improve, some of these “horror stories” may no longer be likely to occur. However there is certainly still transphobia and cisgenderism in trans and non-trans specific healthcare which cannot and should not be ignored. Strategically deploying mistrust, much like deploying personal narrative, can make for more adept patients. As Pearce says:

> “I *know* that transphobia and cisgenderism are common; some level of mistrust feels like a rational, strategic response that enables me to manage my expectations for the future and reduce uncertainty.” (2018, pg. 154, original emphasis)

So in many ways the material here that makes up TransLiteracy is readying trans people for all of the difficulties and complexities that have been described in the previous chapters. It is shrewdly preparing them for the worst so that at least they are not surprised by barriers to good health and quality healthcare when they encounter them, and hopefully it is helping them to overcome those barriers that do arise.

The Methods

Social Media

Like many other marginalized groups trans people have turned to online spaces in order to build communities and exchange information (Mehra et al., 2006). These spaces are frequently focused on community education where members can be alternately student and teacher. Some individuals may be valued more highly as educators due to their level of experience, for example someone who has been out and navigating the healthcare system for twenty years will have a wealth of knowledge to share with people who have only come out more recently. This can be seen in spaces such as Facebook groups where there will be a few more experienced members who are the most frequent commenters and may act as group moderators as well as on YouTube where a single channel may only have one or a few educators speaking to many more viewers. However, within each platform as a whole the fact that anyone with the resources to do so can comment on a Facebook post or upload a video makes the knowledge production and dispersal decentralized.

Media studies scholar Mark Poster noted in their 1995 paper *Postmodern Virtualities* that it was the telephone rather than the television or the radio that was the most radical new communication form during the first media age precisely because it is decentralized. Anyone with a phone can be the message sender or the message receiver and people switch between roles in different times and in different exchanges. The traditional barriers to who gets to construct a message to be broadcast are eliminated when the majority of people can pick up a phone and relay their message to any individual they can call. In the modern media age this is echoed and amplified by the internet, particularly the social internet. As Poster sees it, the internet “combines the decentralized model of the telephone and its numerous ‘producers’ of messages with the broadcast model’s advantage of numerous receivers” (1995, pg. 91). It is this decentralized model that allows for trans people (and other marginalized people) who do not have easy access to broadcasting their message through mainstream media to tell their stories. The internet in general and the social internet specifically are uniquely friendly to transness. Certainly not in the sense of using the internet as a trans person, which is often rife with harassment[166], but rather the structure of the internet independent of its users. The internet queers temporality; it is an archive where old and new content co-mingle and nothing is finite. The internet is fluid and changeable, content can be deleted and edited, autobiographies are continuously updated, communities emerge, change, and die out. It allows for multiplicity of identity; one can have multiple profiles on a single platform, multiple profiles across multiple platforms, all of which can have a unique personality, tone, aesthetic, identity, and audience. In this way it is no surprise that the internet has emerged as a key place where trans people can go to better understand their relationship with gender, to find and build communities, and participate in the information exchanges that develop TransLiteracy. Specifically, as it is relevant to this dissertation, the internet more broadly and social media in particular are places trans people go to seek and share information about health and healthcare.

YouTube and Vlogging

With the advent of the video sharing platform YouTube in 2005 and its subsequent rise in popularity[167], creating video content and reaching an audience became more widely accessible. This has become an important avenue for trans people to find information, especially young trans people and/or those just beginning to understand their gender identity. In my years of watching trans YouTube content I've come across videos discussing different facets of identity, tips for altering gender presentation, advice on coming out, records of changes from taking hormones, experiences of different surgeries, tips on accessing healthcare and navigating bureaucracies, and so on. The first hand experiences of other trans people can be invaluable, particularly if someone does not know any trans people in "real life".

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[166] Another dissertation could be written on the various forms of online harassment faced by trans people, however within the scope of this dissertation I am focusing on how trans people and communities use the internet as a tool to overcome healthcare barriers.

[167] According to Omnicore, YouTube currently has 1.57 billion active monthly users and five billion videos are watched each day (Aslam, 2018).

YouTube was absolutely crucial for me as a young queer person. I did not see positive trans role models in the media and I did not know any openly trans people personally so I sought out videos from people who would talk about their identity and document their transition. This pursuit gave words to the feelings I was experiencing, provided a sense of hope that I could one day be myself, and introduced me to a community I belonged in, all of which were beneficial to my mental health. Adam also found YouTube videos helpful in understanding his identity, he recalled identifying with vlogs and blog posts by trans people as well as a YouTube series created by a non-binary therapist which answered a lot of questions he had while coming to terms with being trans and starting his transition. He even recalled being surprised when he related to a specific YouTuber:

> “I didn't think that this is where I would identify as strongly but it's amazing that I do, I find a lot of the time that I actually identify with Kat Blaque[168]…when she refers to her transness because…I was watching a video yesterday…and what she said was 'I think of myself as a woman with a trans history' and I immediately was like there it is” (Adam)

Despite Adam having a different gender experience than Blaque, when he heard this specific way of describing transness he could immediately relate to it. He now uses that phraseology to refer to himself, describing himself as a man with a trans history. It is also interesting that he was watching this video the day before we spoke. Although he was no longer at the early stages of understanding his gender identity and was already on testosterone, he was still consuming content by and learning from trans YouTubers. Similarly when another participant, Dan, was describing an experience he was currently dealing with he said, “I remember watching, I think a YouTuber that said your dysphoria just kind of shifts and you don't lose it”. He had gotten the words to explain his experiences and confirmation that his experiences were normal from a YouTube video, even as someone who was already comfortable in his gender identity and had made significant progress toward his transition goals. Another participant, Holly, also mentioned watching YouTube videos, a comment that caused her to break out in

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[168] Kat Blaque is a Black trans woman who uses her YouTube channel to speak about many feminist and political issues.

laughter. She went on to elaborate that as an older person that helped her to hear some perspectives from younger people. She herself made a YouTube video to come out as HIV+, another part of her experience that she felt was important to speak about openly and publicly.

Where Adam, Dan, and Holly benefitted from watching these videos, Ben lamented that when he was young the selection of trans YouTube videos was not as large and varied as it is today:

> “You know like I remember looking for videos when I was like 17-18 and there was like three or four people and they were all really far along the line so you didn't really relate and you didn't really understand what was happening you know. But now it's all over the place so I feel like I'd be a lot better off.”

For him, not having content that showed people at the beginning stages of understanding and realizing their identity made it difficult to relate to the content. He feels that were he coming to terms with his identity today he would have benefitted greatly from the content currently available on the platform. This highlights the importance of having a diversity of representation on places like YouTube, not just in the sense that trans content is available but that the trans content is itself diverse. This means representing a variety of identities under the trans umbrella as well as different experiences, transition goals, races, ages, etc.

The importance of these trans related vlogs is not just the impact for the viewer but what the process means for the person making the videos. Even in the very early stages of the internet, Mark Poster remarked that “the appeal is strong to tell one’s tale to others, to many, many others” (1995, pg. 91). This drive to tell one’s story is strong within trans communities and for many the act of discussing their gender identity and experiences as a trans person, documenting the process of their transition, and engaging with an audience are a crucial part of the way they enact their transness. As communications and trans studies scholar Tobias Raun puts it, vlogs:

> "engender the ongoing process of ‘becoming’ man/woman/trans by (re)learning, testing, evaluating in front of the camera the act of gender. This includes using the vlog as an extended mirror, inscribing the vlogger in multiple and

> intersubjective reflections, being visible to themselves and others as an image – an image that they can engage with and/or that others can support and confirm." (2016, pg. 376)

Being out as trans on the internet is a declaration far more public that can reach far more people than most individuals are capable of doing offline. The act of making this public declaration helps cement a self-awareness of one's (trans)gender identity while simultaneously allowing for experimentation and growth. It is also through this process that both the video creator and the viewers are learning and developing the skill of crafting an autobiographical narrative, something they will need to deploy to access healthcare.

The role of the supportive audience in this relationship is to encourage and confirm. By engaging with other trans people or with cis allies on these social media platforms people have their gender affirmed and receive encouragement to continue moving forward. There are of course also unsupportive audiences who misgender, deadname[169], and otherwise harass that trans people have to deal with. Despite the nature of the YouTube platform putting the power in the hands of the creator to decide how they want to present themselves, their message is not always decoded in the way they would hope. Much like with constructing a body image (Chapter 3) and a gendered archive (Chapter 5), some people will actively reject and resist what the trans person is trying to create. As art theorist and philosopher Jorella Andrews says in *Showing Off!: A Philosophy of Image*,

> "…to be a focus for attention, does not mean that you will be seen or heard on your own terms. There are other conditions of perception and reception at issue, including the fact that relationships between expression and reception, between self-showing and being seen, can never be guaranteed to be reciprocal no matter how apparently unmediated they might be." (2014, pg. 54)

This comes into play on trans YouTube when you have people who, for example, will always see a trans woman as a man no matter how much she explains and defends her

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[169] Deadnaming is calling a trans person by the name they were given at birth (or any old name) after they have changed their name to one that is more comfortably gendered for them. When this is done maliciously it is a way of invalidating the person's gender by refusing to call them their chosen name.

womanhood, or people who cannot accept the existence of non-binary genders. No matter how much control a platform offers a content creator, they can never fully control how any individual viewer or the audience as a whole will perceive them.

From the perspective of the viewer of a YouTube video, the specific format of the platform is part of what makes it so uniquely valuable; particularly the fact that YouTube is a video medium and that public videos can be searched for and found by anyone. The combination of visual and auditory elements in a video medium are specifically useful for documenting transition[170]. For viewers who are sighted, people can specifically show outfits, demonstrate hair, makeup, and grooming techniques, and detail physical changes from hormones and/or surgery. For viewers who are hearing, people can document vocal changes from hormones or surgery. The combination of the visual and the auditory along with the common blog format of one person speaking directly to the camera makes these videos seem personal. They are relatable because of their content but also because they give the impression of talking one on one with a friend. The public nature of YouTube and the fact that videos can be found by searching for key words is also important as it improves access. People do not need to belong to a group, have any connections with trans communities, or have come out in any way. Ben and I both turned to YouTube early on in the process of understanding our gender for this very reason. Anyone with unrestricted[171] internet access who is curious about gender diversity can go on YouTube and view content made by trans people. This in addition to the value of the first hand knowledge and experience being shared makes it a great resource for people in the early stages of understanding their gender identity. It gave me the language to comprehend the way I was feeling and showed me non-cis possibilities for being in the world. The fact that you can search by specific topic (such as “facial feminization surgery” or “two years on testosterone”) and the way that many vlogs document someone’s experience over a length of time and through different points in their transition also makes it valuable for people at all different stages of their

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[170] Michael Rich and Richard Chalfen similarly found that the combination of the auditory and the visual was advantageous in their 1999 study on children with asthma educating health care providers through the creation of videos.

[171] Internet usage may be restricted by only being able to access the internet on public computers, having internet usage surveilled by family members, etc.

trans experience. Even someone who has been out for many years and has achieved some of their transition goals may turn to YouTube for information about the next surgery they want, for non-transition related advice, or just to watch someone they can relate to. The act of creating videos can also be a crucial part of being trans, helping people negotiate gender and build community. There is no discussing contemporary trans communities in the U.K. without discussing trans YouTube.

Facebook

While it is important to have this content openly available, it is also valuable to have spaces that are more private. Some trans people, such as those who are not yet out or who are stealth, may not feel comfortable participating in trans YouTube spaces precisely because they are so easily accessible. Others who are not concerned about people knowing they are trans may not want to discuss specific problems or ask "embarrassing" questions in such a public forum. This is where other platforms come in. While YouTube is traditionally more open and public[172], Facebook offers opportunities for more private discussions. Within an individual's page they can choose from a range of privacy settings to curate who sees any of their posts. This way someone could, for example, prevent certain family members from seeing their coming out post or limit a post about a specifically trans experience to a select group of Facebook friends. There are also many closed and secret[173] Facebook groups dedicated to trans people and different subgroups of trans people. In such groups it is possible to limit who can post, view posts, and comment to only trans people, only trans women, only transmasculine

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[172] There are unlisted and private videos, but from the perspective of the typical user YouTube is an open, public platform.

[173] When creating a Facebook group you have one of three options for the level of privacy. The first is to make it "public", meaning anyone see the group, who is in it, and the posts. The second level of privacy would be a "closed" group where anyone can search for and find the group and see who is in it but only members can read the posts. The final option is a "secret" group where only members can find the group, see who is in it, and read the posts. In order to join a closed group you would only need to search for the group, request to join, and have an admin accept the request. However to join a secret group you need to be invited to join by a current member of the group and approved by an admin.

people, only non-binary people, etc[174]. Group membership can be further specified by career field or place of work, hobbies and interests, or specific experiences. Dan found this when he was researching bottom surgery options, “with abdominal phalloplasty… there’s loads of different secret groups that you can go to on Facebook and they give you a little bit more information”. He found that joining a group that is only for people who have had abdominal phalloplasty or who are considering that specific procedure he was able to get the first hand experiences and information that helped him decide that that was the right surgery for him. This first hand information is only available in this format because people who may not feel comfortable sharing intimate details about and even pictures of their genitals in a more public forum feel they can do so in this more private space as well as because this type of content would be flagged or removed from many more public platforms including if it was shared on a public Facebook group or profile.

I belong to a number of trans Facebook groups which I use to get information about many of the topics I outlined at the beginning of the chapter. In one Facebook support network I am a part of I have posted seeking advice on how to deal with people’s transphobic reactions when they find out the topic of my PhD, looking for inspiration as to what gender neutral parent name my future kids could call me, asking what to bring to the appointment with my GP when I was asking for my referral to the GIC, celebrating getting my GIC referral while seeing if anyone had any advice for what to expect from the waiting process, looking for recommendations for masculine dress shirts that would fit my narrow shoulders, excitedly sharing that I had become an uncle with people I know wouldn’t balk at my use of the masculine term, looking for a lead on a trans-friendly GP in the new area I moved to, other positive moments of gender euphoria[175], and jokes that would only be funny to fellow trans people. Some of these were instances of directly seeking advice or information about accessing healthcare but

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[174] These types of closed and secret Facebook groups which are limited to people with a certain shared experience are important sites of information sharing, support, and organization. There are Facebook groups for young people with ADHD (Gajaria et al. 2011), parents of premature babies (Thoren et al. 2013), people with breast cancer (Bender et al. 2011) and many more such shared experiences.

[175] “Gender euphoria” is used by some trans people to describe the feeling of being super comfortable in your expression/body and/or having your gender affirmed. For example one might say that a stranger correctly gendering them or pulling off the perfect smoky eye gave them gender euphoria. It is a play on (and in some cases a resistance against) the term “gender dysphoria”.

all of them were positive for my mental health. Each question I asked was met with many helpful answers and every post with words of support. I have also had many opportunities to comment on other people's posts and offer my experience, assistance, or words of encouragement[176]. Along the way I am continuously learning how to navigate the NHS and the world as a trans person along with the knowledge that I am not alone in this experience.

Facebook can also serve another purpose, it can be instrumental in someone's coming out process. As you can have your name, gender, and a picture of yourself as part of your Facebook profile, it can be somewhat fraught for someone in the early stages of coming out as trans. I recall the day I changed my gender and pronouns[177] on Facebook as a pivotal moment in my coming out. It was the first time I was publicly declaring my transness as I had previously only talked about my gender one-on-one with close friends. Updating my profile picture to one with a more masculine presentation was also important. Adam had a similar experience, but as he was changing his name as well and did not want to have to deal with untagging and deleting old pictures where he looked more feminine, he took a slightly different approach:

> "When it came to my Facebook, my social media, I sort of actively created a completely new Facebook and deleted the old one and added the people that had known, that I had had those conversations with, to that new Facebook. And then it, I think other people maybe that I wasn't as close with saw the new Facebook profile with a new name attached and saw in the picture that it was me and so asked people that they saw who were mutual friends with me what the deal was with that and then those people acted as proxies"

For Adam, Facebook was a tool he used to help him come out. He made an entirely new account so he could have a fresh start and initially only added the close family and friends that he had already come out to. Then when he started showing up as a suggested friend on other people's Facebooks he gave his friends who already knew

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[176] See Pi et al., 2013 for more on what motivates people to share knowledge in Facebook groups.

[177] Facebook has a myriad of options to describe your gender and does not limit you to only one descriptor, for example on my own Facebook profile under "Gender" it says "Trans, Non-binary and Genderqueer". It also allows you to choose between "female" (her), "male" (him) and "neutral" (them) pronouns. Other gender neutral pronouns are not available and under the "Interested In" section you can still only select "Men", "Women", or both.

his gender history permission to come out for him, saving him from having to have as many coming out conversations as he otherwise would have. Others keep their same profile, simply changing the name and/or profile picture, sometimes coming out to their friends in a Facebook post.

In this way, Facebook is acting not only as a way for trans people to educate and learn from each other but also as a platform for trans people to educate their broader social network. This can certainly take the form of trans people sharing articles, linking to websites, or creating their own posts about trans issues in order to educate their friends and family. However the type of education I am discussing here is trans people educating their Facebook friends about themselves. This can occur through the use of explicit and implicit identity statement where “explicit identity statements often take the form of autobiographic descriptions given by the users” and “implicit identity statements can be found in the impressions 'given off' by the users” (Zhao et al., 2008, pg. 1820). An explicit identity statement in this example could be a formal coming out post where the person explains their gender along with things like the story of how they came to understand their gender, unveiling a new name, and/or declaring new pronouns. When looking at disclosure on social media of LGBTQ identity amongst young people, media and communications scholar Stefanie Duguay found that Facebook, specifically as opposed to Twitter, was seen as a reflection of your personal identity.

> “With the platform’s large volume of content, participants stated that LGBTQ-related messages also seemed subtler on Twitter and that it was a more appropriate space than Facebook for this subject matter. Holly, who does not express her lesbian identity on Facebook but frequently tweets about LGBTQ topics, affirmed that Twitter ‘is more political generally as a medium... If someone saw something on here then they’d be more likely to think that it was just a political statement rather than actually sort of who you are.’” (Duguay, 2016, pg 901)

Posting queer content on Facebook was avoided by these participants for precisely the same reason others choose to post there, because a post on Facebook is seen as an identity statement. Such a statement can be posted publicly, for Facebook friends only, for a specifically curated subset of Facebook friends, or can be slightly more private. For example while I never made a dedicated coming out post on my public Facebook profile, I officially came out to my siblings over Facebook messenger a few years ago with this message:

> “Hey sibs, I know I’ve talked about this a bit with all of you but just wanted to clarify for pronouns purposes and such. So as you may know I identify as Genderqueer. Genderqueer refers to trans* people who don’t identify within the gender binary so are not male or female a.k.a Non-Binary. My pronouns are They/Them/Their and my title is Mx. as in Mx. Callahan (hopefully soon to be Dr. Callahan though!). Also just other gender-neutral terms like “sibling”. If you have any questions, just ask! Love you all 🙂”

This is the very definition of an explicit identity statement and is useful in getting important information about one’s identity across quickly and clearly. Zhao et al. (2008) found however that implicit identity statements were more common on Facebook. For trans people this can mean changing their profile picture to one where they have a certain gender presentation, changing their pronouns, posting photos of themselves at trans events, etc. These two avenues of proclaiming identity on Facebook are an important part of the process of understanding, constructing, and publicizing one’s relationship to gender[178].

Other Social Media Platforms

Some participants discussed finding information beyond YouTube and Facebook[179], such as Carey who found a blog particularly helpful:

> "I know another, well I don't know I follow their blog, another non-binary person in Wales who has just had top surgery without going on hormones so I know that that is a thing cause I was, most of the information out there is like you go to your appointment and then you go on hormones and then like a couple of years down the line then we'll see about whether you can have surgery or not. But because I don't think I wanna go down the hormones route I was like 'ah oh my god does that mean that I'm never gonna be able to have surgery unless I go

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[178] This is particularly true for people who use Facebook as their primary social media platform, but any platform that someone uses heavily is specifically suited for coming out because that message can easily reach a wide audience.

[179] Past use of online platforms was also referenced, such as Emily who was previously active in now defunct Yahoo groups.

> on testosterone?’ And then I found other people who are like 'no, you don't have to change your body in ways that you don't want it to change you can change it in the ways that you do want it to change’ and that was reassuring”

Carey was able to find someone they could identify with who had accessed the things they hope to access, assuring them that their transition goals are possible. Instagram is another outlet that did not come up as frequently in interviews but there is certainly a strong trans presence on the app. I personally follow trans friends, trans celebrities, accounts that repost or post submitted pictures of trans people, and the accounts of trans owned businesses. When Holly was struggling with her identity, she also found solace on Instagram:

> “I went online, so I started seeing a lot of uh YouTube videos *laughs*. A lot of that and I became friends with people online, Instagram mainly, that's what start changing my perspective. To see especially younger people to be quite assured that they don't need to define themself…it kind of opened my eyes it was like ‘wow'. So you realize how constructive your mind is to forty years of a binary society that says ‘that's male, that's female, and that's the sick trans person, that's it there's nothing else’, so…I realized how narrow my mind was”

Holly looked at YouTube videos as well but found that Instagram was specifically helpful. As a forty year old, Instagram helped her make friends with younger trans people that she may never have met offline. These younger people introduced her to the concept of being non-binary and showed her different models of transness at a time when she was struggling to understand her gender. She knew she was trans and feminine but the label of trans woman did not feel right and the community she found on Instagram helped broaden her concept of gender and understand her own experience of gender more fully.

Ruth Pearce found that Twitter is another site where trans knowledges are shared and legitimated. She specifically looked at the use of #transdocfail, a hashtag used primarily by trans people sharing their negative healthcare experiences. She found that:

> "a unifying feature across the hashtag’s approximately two thousand tweets is the promotion of personal trans knowledges and experiences as *credible*…

> Twitter therefore provides a platform for individual accounts to be collectively and mutually (re)constructed as credible, with these knowledges affirmed through iterative repetition in a public space". (2018, pg. 172)

This social media platform provides not only a valuable resource for the trans reader of the hashtag (which doctors to avoid, what experiences to expect, etc.) but also a refreshing opportunity to have their experience believed and regarded as important for the trans person sending the tweet.

Some participants also made use of Twitter in a different way. Flora follows their private gender specialist on the platform to keep up with any practice updates that may be relevant to them. At a time when they were not happy with how difficult it was to get ahold of the practice they saw this post:

> "from [his] Twitter once I saw, they were in a pub and it was like 'secretary meeting' or something and I was like right…so this is your business. Do you know what I mean like, so I just I on the one hand I'm sort of like it's humorous but then on the other hand I'm like so this is why you take forever to reply to my emails" (Flora)

Of course it is possible that this post was a joke and Flora did find it a bit funny, but they also found it to be quite telling. To them it explained the difficulties they were having reaching the secretaries and painted the practice as somewhat unprofessional in their eyes. Trans people are not only using social media to get information from other trans people, they are also using it to get information directly from medical care providers, in this case via monitoring their posted content.

In the same way Holly used Instagram to connect with fellow trans people, Ingrid has used Twitter to connect with potential care providers. When we spoke she was in the process of trying to access continuing hormone replacement therapy as her current private provider is retiring soon. She was struggling to get a prescription through her GP and reached out to another private provider but received no response. Being many years on hormones and post bottom surgery, she believes this is because that provider is "just not interested in dealing with somebody who just needs a hormone prescription, she's looking for people who want to go through the whole system" (Ingrid). She was becoming worried that her hormone regime would be interrupted so she was planning to get in touch with another private provider that she was familiar with online, “I know [him] a bit from Twitter so I'm hoping that an email to them might actually get me a prescription, failing that black market probably” (Ingrid). She was hoping that her online connection with this provider will mean she won’t be ignored like she was with the other practice. If that is unsuccessful however she recognizes that accessing hormones without a prescription will have to be her last resort. Holly and Flora are both self-curating a mixture of professional (calling and emailing care providers directly) and social (Twitter) communication to access healthcare and information.

Getting information online is not always a positive experience. Ben recalled looking up trans experiences the first time he tried to start his transition when he was nineteen. He found some information, but did not learn the skills to navigate the NHS bureaucracy. He approached his GP hoping to get referred to a gender clinic but his GP refused and insisted he was not trans. Not being armed with enough information and not being as assertive in his own estimation as he is today, he accepted the GP’s decision and did not pursue his transition for a few more years.

> “I think I was aware of testosterone but I had all these strange ideas because… you’re just scrambling around in the dark really. You're just looking for things online and certain people say some things and then you get confused who's who and everything. So I was taking information from like both sides, so trans women were talking and I was confused, I was like, ‘is is that me?’ like I didn't know what the terms were, I didn't know…any of these things. Like I kind of had this idea in my head that testosterone, you take it for five years and then you're good, like you don't have to take it again, because somebody online said that, you know the maximum effects happen after five years or something. So for like two years I thought that's what the deal was, I can take it five years and then I'm good to go. But I was completely in the dark and that first experience was pretty dire for me, I guess I think if I had been more clued up, if I understood what I was actually going for, then it wouldn't have been so bad. But because I was literally just reaching out to this person…I didn't have anything in mind, I didn't think ‘oh I wanna get on testosterone’, I was just like 'I need some help, like I'm feeling terrible’. I was just literally asking for help and they totally shut me down.” (Ben)

Ben had access to all of this great information but not to a community or anyone to contextualize and explain it. He learned that for most people they stop seeing changes after a few years on testosterone, which is true. However he was missing further information, that you can lose some of those changes by stopping hormones and the risks of not maintaining hormone levels. The education here was decentralized but it was not social and both aspects are important for TransLiteracy. Without that crucial element he became more confused and did not have the tools to advocate for himself more fiercely with his GP at the time.

Offline Education

Being able to learn and make use of all this information to self-advocate is a skill within itself that trans people acquire to access their healthcare. While some of the information is used online (sending emails to care providers, downloading forms etc.) much is also used over the phone and in person. In this way trans people also learn by doing. Their experiences with healthcare providers inform future tactics for accessing healthcare and give them information which they can later pass along to other trans people. For example, if someone goes to their GP to get referred to a GIC and they get asked certain questions, they will be more prepared to answer those same questions once they get to the GIC. If their GP outright refuses to give them a referral, they can then warn other trans people to avoid that GP. This information can be distributed online but there are also important offline modes of teaching that trans people use, specifically in-person support groups, social events, activism, and informal discussions between friends. For Dan, meeting other trans men in person was an important learning experience. He explains:

> “I'd started to meet other trans guys, cause up until that point I didn't know any other trans guys, and I listened to everyone else's experience and everyone else's recommendations and then you know I'm doing my own research and actually it's it is quite hard if you don't know exactly what you're looking for to to see what you're supposed to get and or what route should be or which testosterone is gonna be better” (Dan).

Dan continues to attend trans support groups and meet-ups to continue to learn and to share what he has learned with others. Flora had the experience of having a trans person in their life prior to realizing they were trans. They learned a lot about the process of accessing transition related healthcare from their long term partner who is a trans man. While that knowledge was useful, having a trans partner did not help them realize they were trans.

> “people sort of say to me 'oh was it, was it [your partner] who made you realize that' and I'm like 'no' because he's so binary that I, you know we have similar, I mean we're both on hormones, we've got similar identities but, no. Because we both went to the same all girl's school and it was the most traumatizing thing in the world for him as you can imagine a boy in an all girl's school, but for me it was fine. Cause I guess I'm such a feminine person I fitted in and yeah I had problems with like puberty and with getting curves and just not understanding and hating it and just like periods and being like 'what the fuck’…but because I'm gender fluid and I can still connect with the inner, I can connect in my own way to girlhood and I guess the beginnings of womanhood…whereas…that for him is like alien and just you know completely like dividing line” (Flora).

Flora did not see themselves in their partner’s experience and so did not realize at first that they could be trans as well. I had a similar experience in school where the first, and for a long time only, out trans person I knew was a trans boy in the grade above me. His experiences, such as being so certain he was a boy (I was certain I wasn’t a boy) and being excited to start testosterone (I did not want the changes that testosterone brings) were so different from what I felt that I did not realize that I could be trans as well. Of course as I grew up and met more trans people I realized how diverse of an umbrella it is, but these experiences that Flora and I have had highlight the importance of being able to find possibility models that you can relate to.

One of the wonderful surprises that has come from this research has been how much the participants have taught me, not just about their own experiences but they have passed along information that will help me navigate being trans in this country. Within the interviews themselves, this exact model of social, decentralized pedagogy was taking place. Dan taught me about a new method for phalloplasty that I had not heard of before. Carey told me how to go about finding an affordable, queer-friendly therapist. Adam was going through the early appointments at his GIC when I interviewed him and he helped me decide to be referred to that same GIC and gave me a run down of who all the people there were and how to navigate their different personalities. He also introduced me to the ins and outs of gel testosterone and the possibilities for taking lower doses with that method. Flora, who is taking low dose testosterone themselves, relayed their experience with it in generous detail which has helped me consider the same treatment for myself. Flora and I also stayed and talked at length after the interview, as they were an undergraduate student at the time, I was able to offer them some of my own experience dealing with the university system as a non-binary, transmasculine person. George gave me advice on options for freezing eggs and recommended the fertility clinic him and his partner used as being trans-friendly. As we were both engaged to be married at the time, after the interview I was also able to give him some advice regarding navigating wedding bureaucracies as a transmasculine person. Ingrid gave me valuable insights on challenges I may face as an older trans person and when I have progressed farther toward my transition goals. Emily has a lot of inside knowledge into the NHS and provided me with information on what specifically the GICs are looking for that may be useful when I start going through that process. Holly also had some useful first hand information as a healthcare worker. Ben taught me how to make sure your blood work is done correctly and how to decode the results when testing testosterone levels. He also informed me that in his experience private providers are more supportive and clued me in to how that process works and how much it would cost should I want to go that route. These are only the key learning moments that have come as a result of this research project, there are countless more that have emerged from unrelated interactions within trans communities. Much of this information is relevant to me and will likely help me at some stage of navigating my healthcare as a trans person. Even the information that I will not personally need, the more I know the more I can pass on to other trans people I come across who may need that information.

Looking Forward

As a product of trans communities that will be fed back into trans communities, this dissertation is another form of exactly what I am discussing throughout this chapter. Indeed, the promotion of TransLiteracy is a key goal of this dissertation, as I discussed in the introduction. It is crucial to make the lessons of this dissertation accessible to trans communities so they can make use of them, whether that be in a practical (such as learning how to best access transition related healthcare) or theoretical (such as rethinking how sex operates socially) way. This sharing of knowledges, self and peer education, and community building are an integral part of my research dissemination model as I discussed in Chapter 1. These methods can also promote and develop new ways of understanding sex and gender (Chapter 3), are contributing to the demedicalization of transness through education and community organization (Chapter 4), and can help individuals navigate complex medical bureaucracies, negotiate time, and navigate spaces (Chapter 5). It is through this social and decentralized pedagogy that trans people have been able to develop their TransLiteracy and thus improve their health and ease their access to healthcare. It is crucial that this form of pedagogy not only continues but becomes more accessible to more and more participants.

Conclusion

Concluding Argument

A Trans Healthcare System

Throughout this dissertation, I have shown what it is like to navigate cisnormative healthcare systems as a trans person. But what would it look like to navigate a healthcare system that presumed a trans patient? Even if it is just a healthcare system that acknowledges the possibility of a trans patient there would be some major differences. As a standard across health services titles would be written in just like names and would not be changed by admin staff upon seeing the patient's gender marker[180]. In terms of gender markers, sex and gender history would be recorded with more detail or perhaps there would be no need to record a patient's sex and/or gender at all. Relevant body parts (i.e. cervix, prostate, breast tissue) would be included in forms to offer correct cancer screenings and other care and these records would be kept up to date following any surgeries. It would be common practice to ask for or consult notes to determine a patient's pronouns before consultations. In general there would be less multiple choice and more open ended questions on forms and in appointments. There would be flexible ward assignments in hospitals. Most importantly however, transness would not be considered a disorder and transition related healthcare services would be provided on an informed consent basis. It is this idealistic but nevertheless easily imaginable scenario that I describe in the following section.

The Tension of Demedicalization

In Chapter 4 I unpacked the medicalization of transness and the harm it causes through stigmatization and creating barriers to healthcare access, while in Chapter 5 I addressed some of the axes of power that are at play because transness is medicalized. I outlined the gatekeeping practices, bureaucratic processes, long and uncertain wait times for care, and gendered spaces which all put up further barriers

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[180] At every GP I have registered with since starting to use Mx. as my title, that has not been an option so I use Mr. as it is my second choice. However, every time my title ends up being changed to Miss or Ms. without my consent. When I question this I have been told that it is because of the “F” marker in my records.

between trans people and good health outcomes. It is on this basis that I argue for demedicalization, where transness would cease to be labelled as a disorder and transition related healthcare would no longer be provided under the banner of “treatments”. Here is where the central tension of this dissertation lies. If demedicalization is the answer to the harms of medicalization, then what are trans people who rely on being able to access medical technologies to do? While I do see how demedicalization and access to transition related healthcare are at odds within current healthcare systems, I do not believe that it needs to be that way. A model of accessing medical technologies which is based on informed consent at every stage would be able to accomplish both of these goals. Rather than being assessed via multiple third parties to determine what care is allowed, there would be a self assessment. For a trans man seeking top surgery for example, this self assessment would be as simple as deciding that they want and/or need their breasts removed[181]. They would then refer themselves to the surgeon of their choice in a similar fashion to the process for self-referral to physiotherapy which I outlined in Chapter 5. The surgeon would then obtain informed consent and perform the procedure. This is not as big a shift as it may seem. Other aspects of human diversity have already been demedicalized (like homosexuality) and other services already operate on self referral (like physiotherapy). Self assessment and informed consent are already aspects of the process for accessing transition related healthcare, thus, this model is simply about removing the other aspects of the process that serve as barriers, namely long wait times for appointments with multiple third party gatekeepers who are applying inconsistent and often inaccurate definitions of gender and embodiment. I cannot say how likely this model is to come into effect, but if the barriers to quality healthcare and good health outcomes are not identified and alternative models are not proposed then things will certainly never change.

Concluding Summaries

Methodology

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[181] This step already occurs when an individual is deciding to be referred to a GIC or is deciding which referrals they are going to request from the GIC.

In Chapter 1, I laid out a model for a trans methodology which I have worked toward in this research and will continue to develop in future projects. This is one of the most broadly applicable contributions of this dissertation as it can be applied to many fields of research, particularly those that study marginalized groups. This model had four components. Firstly, the research is completed within the communities. This includes research on trans people being done by trans people but it can also expand to research on race and racism being done by people of color, research on disability being done by disabled people, research on refugees being done by refugees, etc. I believe that the access granted to a community member, the intimate first hand knowledge of the topic, and the lack of a fascination with and presumed expertise of “the other” are valuable tools that can produce rich research data. The second feature is that interviews (and other first hand narrative accounts such as autobiographies) are particularly valuable. The key is allowing trans people, or whoever is being researched, to give their experience in their own words. Trans people are the preeminent experts on their own experience and an important part of this work is demonstrating that and valuing trans knowledges. In combination with the first component, this allows for the use of autoethnography as I have done here. Thirdly, research using this methodology would deploy a trans writing style as I have demonstrated throughout this dissertation. Two of its key features are not presuming to be able to determine someone’s gender without them articulating it themselves and keeping everything rooted in the current moment, recognizing that things have and will continue to change. The fourth component of this trans methodology is that the findings are fed back into the communities in an accessible way. This part is yet to occur in terms of this dissertation but in addition to the usual conference talks and journal articles I plan to create summaries in easy to read language which can be disseminated online or in print to the places I originally recruited participants from, as well as in new online and offline spaces of which I have been more recently aware including various Facebook groups, email lists, and support group meetings. I will also create a short presentation and offer my time to different trans groups that may wish for me to come and discuss these findings. It is this outline for a trans methodology that I hope to continue to employ and build on throughout my career and thus I consider it one of the key findings of this dissertation.

Sex and Gender

Chapter 3 worked toward a better understanding sex and gender and the way those two concepts relate to each other. This is crucial as it is this understanding on which the rest of the thesis operates. The conclusion I drew in that chapter is that the sex gender distinction while, at one time practical, is no longer useful. Sex and gender are in fact intimately related in that gender can influence sex. This is possible because sex as well as gender is socially constructed and self-determined. Both have deeply important social meanings and are constructed and articulated individually through practices of gendered presentation, embodiment, and intra-action. Both sex and gender being self-determined and self-determinable paves the way for both morphological self-determination and thus the informed consent model of accessing medical technologies that I have discussed above and for trans people who do not wish to alter their bodies in the linear, binary way or in any way at all. It is an important opening up of possibilities that allow for greater human diversity and challenges existing classificatory systems.

TransLiteracy

Another key finding comes from Chapter 6 where I described TransLiteracy, or the sum of the skills and knowledge trans people accumulate in order access quality healthcare and good health outcomes, and how it is disseminated and received. Just as with the methodology, this concept could be applied more broadly to understand the specific knowledges any marginalized group accumulates to navigate healthcare systems. Seeing how this community education occurs, in a social and decentralized manner, has practical as well as a theoretical implications. Valuing and promoting this type of pedagogy which takes place outside of any one institution, has flexible and overlapping understanding of “teacher” and “student”, and is contextualized within communities could help trans people overcome barriers to good health outcomes until those barriers can be removed.

Limitations

The most prominent limitations of this research are the various limitations of the participant group. While each voice in this dissertation is valuable and important, it is still a relatively small group of interviewees. That group is also limited to English speakers as I regretfully only speak English and it is heavily biased toward Londoners. While not every participant lives in or is from London, me being based in London for the duration of this project has limited the participation pool. With more time and resources for recruitment, future research where more interviews could be conducted would build on this work significantly. Additionally the participants were majority white, transmasculine, and under thirty-five. I can not say for certain why this is the case, but it is not lost on me that the I am also white, transmasculine, and under thirty-five. Future additions to this work and trans studies in general would benefit from the voices of more Black people, people of color, trans women, transfeminine people, young people, older people, and people at various intersections thereof. In order to accomplish this more targeted recruitment will need to take place and potential issues of accessibility and safety will need to be addressed. The specifics of these measures could be worked out in communities, but they may include providing compensation for the time it takes to participate, interviewing people in their own homes or in other more private locations, and reaching out to various minority support groups rather than just general trans groups. Finally I was also limited in fully understanding the diversity of my participant pool by only tracking age, race, gender, and pronouns. In future research I will collect more information about socioeconomic class, religious affiliation/belief, immigration history, disability and health, educational attainment, work, etc. in order to ensure a diversity of perspectives and to see where in-group patterns may emerge.

Future Research

There are so many exciting lines of inquiry that this dissertation has raised, some of which I have identified in the footnotes throughout. It would be particularly interesting to workshop trialling an informed consent practice, if NHS cooperation could be obtained. However, the most pressing call for further research at the moment is to expand this project to include people from all over the U.K. and ideally in other countries as well. Additionally, I propose a need for further similar research to be done by a more diverse group of scholars. In line with the methodological model outlined in Chapter 1 which values trans studies research that is done by trans scholars, research that is completed by and with trans women, transfeminine people, Black trans people, other trans people of color, and especially Black and brown transfeminine people is crucial for a full understanding of the field of trans health.

Final Thoughts

At the heart of this dissertation is a call to action. Trans people in the U.K. are not being served by healthcare systems in ways that are respectful, timely, or attentive to their specific needs. One participant, Holly, perfectly summarized the ethos of this entire project when she said:

> “this individual have the right to be protected. A transgender individual…or non-binary, wherever they come from, have the right to be treated equally with respect and a knowledge in the way they want.”

It is this idea, that trans people deserve equal access to quality healthcare that is delivered in a respectful manner by knowledgable providers, which led me to this work in the first place. Throughout this project I have come not only to the conclusions discussed in this chapter but also to a new understanding of my role as a scholar in my communities. Seeking ways to use scholarship to address problems like these, rather than simply to document them, is the best use I can imagine for this PhD and is something which I hope will become a life long project.

Glossary of Acronyms

ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
AFAB	Assigned Female at Birth
AIDS	Acquired Immune Deficiency Syndrome
AIS	Androgen Insensitivity Syndrome
AMAB	Assigned Male at Birth
DSD	Disorders/Differences of Sex Development
DSM	The Diagnostic and Statistical Manual of Mental Disorders
FTM or FtM	Female to Male
GIC	Gender Identity Clinic
GP	General Practitioner
GRC	Gender Recognition Certificate
HIV	Human Immunodeficiency Virus
HRT	Hormone Replacement Therapy
ICD	International Classification of Diseases
LGBTQ	Lesbian Gay Bisexual Transgender Queer
MoJ	Ministry of Justice
MTF or MtF	Male to Female
NHS	National Health Service
ODD	Oppositional Defiant Disorder
PMDD	Premenstrual Dysphoric Disorder
PMS	Premenstrual Syndrome
RLE	Real Life Experience
SOC	Standards of Care
SRS	Sex Reassignment Surgery
TERF	Trans Exclusionary Radical Feminist
WHO	World Health Organization
WPATH	World Professional Association for Transgender Health

Glossary of Medical Terminology

Breast Augmentation	Various surgical techniques to enlarge breasts
Clitoroplasty	The surgical creation of a clitoris
Double Mastectomy	The bilateral surgical removal of breast tissue
Facial Feminization Surgery	Various surgical procedures to create a more traditionally feminine facial appearance
Hormone Blockers	Medication which blocks either testosterone or estrogen production
Hormone Replacement Therapy	Taking testosterone or estrogen to replace the hormones the body was making previously
Hysterectomy	The surgical removal of the uterus
Lipofilling	The surgical transfer of fat to change the shape of the body
Liposuction	The surgical removal of fat to change the shape of the body
Metoidioplasty	The surgical creation of a penis from a clitoris
Oophorectomy/Ovariectomy	The surgical removal of the ovaries
Orchiectomy	The surgical removal of the testicles
Penectomy	The surgical removal of the penis
Phalloplasty	The surgical creation of a penis from a skin graft
Puberty Blockers	Hormones that temporarily suppress puberty
Scrotoplasty/Testicular Implants	The surgical creation of a scrotum with implants
Vaginoplasty	The surgical creation of a vagina
Vocal Feminization Surgery	The surgical shortening of the vocal chords to raise the pitch of the voice
Vulvoplasty	The surgical creation of a vulva

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