PATIENTS, PRACTICE, AND THE SOCIAL CONSTRUCTION OF
TRANSGENDER

by

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This research would not be possible without the participation of my fellow transgender and queer community members who helped spread the word about my research and acted as participants in the study. I hope that this work will contribute to lifting our voices and making the world safer for us all.

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Glossary

**Agender**- Describing a person who does not feel that they have a gender identity that fits current gender models.

**Bigendered**- A person who is experiencing two genders.

**Binder**- A device that is worn to press the chest into a flat contour. These may be made for this purpose or be made of ace bandages or tight clothing such as sports bras.

**Binding**- The act of using a binder to flatten the contours of the chest.

**Cisgender**- An adjective to describe a person whose gender identity is congruent with the socially expected gender of their sex-assigned-at-birth.

**Deadname**- The name a transgender individual was given at birth and which is no longer used by the individual.

**Deadnaming**- The use of a transgender person’s birth name instead of the name they are currently using. This can result in the triggering of dysphoria due to the gendered associations of many names.

**Demigirl**- A person who identifies with a feminine gender, but does not necessarily identify with womanhood or the gender binary.

**Demiboy**- A person who identifies with a masculine gender, but does not necessarily identify with manhood or the gender binary.

**Gay**- While usually a term indicating a man attracted to men, it can also be a term equivalent to transgender within some communities.
**Gender Identity**- The way an individual understands their gender.

**Gender Presentation**- The ways in which a person uses external indicators to communicate their gender to others. This can be done through hairstyles, make-up, clothing choice, body movements, among other social cues.

**Genderqueer**- A person who does not identify with current gender systems or may fluctuate among gender identities.

**LGBT or LGBTQ**- An acronym that indicated a larger social and political community of lesbian, gay, bisexual, transgender, and queer individuals.

**Non-Binary**- A person who identifies as a gender outside of those of man and woman, or masculine and feminine.

**Packer**- A device used to give the appearance of a bulge in the genital region while wearing clothing.

**Packing**- The act of using a packer to achieve a genital bulge.

**Queer**- An umbrella term similar to LGBTQ. Also, an adjective that describes concepts of community and culture within non-heterosexual and/or non-cisgender populations.

**Sexual Orientation**- One’s attraction to others, often identified by the gender identity or presentation of those the person is attracted to in reference to their own gender identity or presentation.

**Stealth**- A term used to indicate that a transgender person is no longer identifying as transgender and has begun to identify as a cisman or ciswoman and chooses not to reveal their previous gender classifications to others.
**Trans**- A shortened form of transgender, often used to signify a broader umbrella. Can also be added to the beginning of nouns to indicate that the noun is transgender (i.e., trans patients, transman, or transfolk)

**Transgender**- An adjective describing a person whose gender identity is different from the socially expected gender identity associated with their sex-assigned-at-birth

**Transfemme, Transfeminine**- A transgender person who identifies as feminine, but not necessarily as a woman.

**Transman, Transgender man**- A transgender person who identifies as masculine or a man.

**Transguy**- see transman.

**Transmasc, Transmasculine**- A transgender person who identifies as masculine, but not necessarily as a man.

**Transmedicalist**- A person who believes that in order to be transgender one must have a formal diagnosis of gender dysphoria and undergo or want to undergo biomedical interventions to affirm their gender.

**Transwoman, Transgender woman**- A transgender person who identifies as feminine or a woman.

**Tuck, Tucking**- The act of flattening one’s penis by pressing it back against the perineum and concealing the scrotum by pressing the testicles into the body or back along the perineum along with the penis to reduce or eliminate the presence of a
genital bulge, or to conceal male genitalia. The genitalia may be further affixed using adhesive tape to prevent accidental untucking.
Patients, Practice, and the Social Construction of Transgender

Abstract

by

DANIEL BASIL HAMILTON

The visibility of transgender individuals in U.S. society has been increasing steadily over the past decades. A rise in demand for gender-affirming care has caused an expansion of care provision across medical systems to enact transition-related practices. Within anthropology, nonbinary gender classifications have been documented and studied through symbolic and functional lenses, but few studies explore the social construction of these identities through the process of gender-affirming care. In the U.S., these procedures are sanctioned within the biomedical system. This research seeks to answer the question, of how transgender patients navigate accessing gender-affirming care in the U.S. This research uses patient experiences with diagnostic and treatment practice for gender dysphoria in a Midwestern U.S. metropolitan area to examine the manner in which multiple ontological perspectives from providers, patients, and healthcare systems come together to enact gender-affirming care.

This research shows how transgender patients: disagree with a progressive gender-affirming care model as currently practiced; strongly disagree with the requirement for therapist letters and would prefer an informed consent model of care; experience the clinical space in unique ways; and gain and share biomedical knowledge primarily through other transgender individuals. These findings suggest the need to critically examine aspects of the biomedical practices within the delivery of gender-affirming care in the U.S. to better patient experiences.
Chapter 1: Introduction

In the United States, transgender individuals often engage with biomedical systems through the enactment of gender-affirming care by undergoing physical transformations of the body to better correlate with one’s sense of gender. The biomedical knowledge that informs these medical practices is documented through diagnostic tools such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) (2013); standardized treatment protocols such as the World Professional Association from Transgender Health (WPATH) Standards of Care (2022); and biomedical literature found in technical books and medical journals. These tools and practices are developed within the techno-scientific culture of the United States and reflect the values and beliefs of that culture in relation to gender.

Within the context of medical care provision, the active role of the patient is less studied, as the medical gaze often depersonalizes the patient. Transgender activists have written about agreements and disagreements with diagnostic criteria and standards of care (Bornstein 1994, Feinberg 1998, Herman 2009), but this is often not reflected in the medical literature. This research uses ethnographic methods to examine several diagnostic and treatment practices for gender dysphoria in a Midwestern metropolitan area to highlight the role of patients in the provision of gender-affirming care and how transgender lay knowledge engages with biomedical knowledge to (re)create a broader understanding of transgender as a category in the United States.

While patient satisfaction is a growing metric for medical systems to measure success, patients are often seen as bodies to be acted upon, rather than actors within their own care provision. Having spoken with gender-affirming care providers in the design of
this project it was often noted that transgender patients arrived in the medical offices with a broad knowledge of the treatments available and clear desires and expectations for the types of gender-affirming care practices they want to access. Desires mentioned included specific hormones, specific dosages of medications, and specific types of surgical procedures.

This study uses a broad definition of transgender as a person whose gender identity is different from the gender identity culturally associated with their sex-assigned-at-birth. The focus on individuals involved with the biomedical system was chosen in order to reduce the challenge that arises in defining a transgender study population based on identity alone. The study population consists of transgender individuals who are receiving gender-affirming care.

This research seeks to answer the question of how transgender patients navigate accessing gender-affirming care in the U.S. By exploring transgender experiences in biomedical interactions, this research reveals how those interactions pattern the understanding of being transgender and the iterative impact this has on care seeking for gender-affirming care across medical specialties. This study takes an ethnographic lens exploring the ways in which “transgender” is understood by patients across the gender-affirming care spectrum and how these understandings influence the sense of what it means to be transgender.

This research aims to understand how patients gain and share biomedical knowledge about gender-affirming care; understand the impact that multiple ontological perspectives have on the provision of gender-affirming care and the perceived outcomes
for transgender patients; and understand how the practice of being a gender-affirming care patient impacts the social narrative of gender and being transgender.

Data were collected through interviews, structured journals, and review of the medical literature and were analyzed by arranging the data into a praxiography (Mol 2002) of medical interactions allowing for a disentangling of the various modes of knowing which comprise medical interactions between patients and providers. This reveals agreements and disagreements in understanding between various actors engaged in the practice of gender-affirming care around the diagnostic criteria and practices themselves.

Chapter two reviews the methods employed in gathering data and analysis. The research methods drew influence from anthropologist, Annemarie Mol, and her work studying ontological multiplicity (Mol 2022) and the logic of care (Mol 2008) in medical settings. Analysis methods also drew from Mol (2002) in mapping out of practices within gender-affirming care, and overlaying patient experiences onto that model.

Chapter three provides a background on two areas of anthropological literature which this research draws upon and contributes to. These areas are anthropology of gender and anthropology of the body. Additionally, a historical review of the practices of gender-affirming care is included to help guide readers through the context of these practices. This serves as a guide to understanding the various medical practices that are enacted in the gender-affirming care process.

The research findings are presented in eight chapters structured in a way to follow the expected movement of a transgender patient through gender-affirming care. This structure is determined by the biomedical expectations of patients and, as will be noted in
Chapter four, is not necessarily the order or specific care a transgender patient may be seeking.

Chapter five explores the role of mental health providers in the provision of gender-affirming care. This chapter looks at the gatekeeping role of therapists as outlined in the WPATH Standards of Care, informed consent models, and the DSM criteria. All of these elements are linked and serve as one of the first challenges to patient autonomy in the gender-affirming care process.

Chapter six presents the role of hormones and hormone therapy in the regulation of the transgender patient. Hormone therapy is a common and more easily reversible step in gender-affirming care. Patients entering care seeking hormones have high expectations for their efficacy and results. Gender expressions are often inscribed onto hormones, similarly to the ways in which gendered language, as noted by Emily Martin (1991), is used to describe egg and sperm cells.

Chapter seven explores patient experiences and views on top surgery. Top surgery may include mastectomy, chest contouring, chest masculinization, or breast augmentation. Top surgery is an important aspect of some transgender individuals’ gender-affirming care due to the gendered emphasis placed onto the chest or breasts in U.S. society. The chest is also a part of the body whose contour is visible through most forms of attire, and can contribute to misgendering or dysphoria.

Chapter eight highlights the role of bottom surgery for patients. Bottom surgeries involve altering one genitals or gonads. There are a number of procedures that are considered bottom surgeries including: hysterectomy, gonadectomy, orchiectomy,
metoidioplasty, vaginoplasty, phalloplasty, among others. The data reveal patients' experiences and barriers to care.

This is followed by chapter nine, which explores the views on other biomedical procedures that were not a focus of study recruitment, but were mentioned by participants such as electrolysis, facial feminization surgery, or vocal cord scraping. This chapter particularly notes the concept of gender and hair, as this was revealed as an important part of some participants' gender journeys.

In chapter ten I look at the clinical space and the types of actors engaged in the social interactions between patients and providers. This chapter broadens the clinic space and looks at the impact of hospital systems, insurance, provider’s offices, receptionist desks, and waiting rooms. These are all aspects of the biomedical care setting and may serve to support or discourage transgender patients. Within this section, LGBT and transgender specific clinics are also explored, as they are currently structured within the hospital systems covered by this study.

Finally, in chapter eleven the interpersonal interactions between patients and providers within the provider’s office are explored. This chapter includes the role of patient authority and knowledge in gender-affirming care interactions, including the sources of patient knowledge sharing. The chapter outlines the indicators that patients use to gauge whether an interaction with a provider was a positive or negative experience and how this information is communicated among other transgender individuals.

Chapter twelve brings together the research findings to present a series of suggestions for bettering the delivery of gender-affirming care, such as reexamining the use of gendered language in biomedical practice; updating care practices; and including
transgender patient authority into the development of treatments and standards of care.

Anthropology and its methods can be utilized to achieve these goals by gathering qualitative data and using that to assist in informing policies and procedures.
Chapter 2: Methods

This research was conducted as in-community research. The researcher identifies as queer and trans, has worked in transgender advocacy and support for over a decade, and previously was engaged in research among other transgender individuals. This facilitated three primary benefits to the study. It eased access to the research population; allowed for trust to be established more readily; and created a space for participants to disagree with established academic and medical criteria with less fear of negative repercussions. This also carried some risks such as participants forgetting that they were engaged in research or sharing things that they would not want to be public. The researcher regularly reminded individuals that they were engaged in research interviews and could choose not to share elements or request redactions of any information provided. A reflexivity statement from the researcher, which includes the researcher’s answer to the initial question posed to participants regarding their journey with gender to date and the researcher’s views on in-community research, is included in the appendices.

The study location for this data was primarily a Midwestern urban city in the United States of America with several competing area-wide hospital systems all delivering some level of gender-affirming care. Not all systems offered all elements or procedures used in the delivery of gender-affirming care. Only one of the systems referred out for all gender-affirming surgical procedures; however, all the others offered some form of bottom (phalloplasty, vaginoplasty, metoidioplasty) and/or top surgeries (chest contouring sometimes referred to as breast augmentation, breast reduction, or chest masculinization). The hospital systems also represent a wide range of patients across socio-economic levels.
As in many midwestern U.S. cities, the research location has been experiencing a decline in population as industries across the region have changed and talent has moved out to seek different career paths. The median household income is in the low $30,000s and the percentage in poverty is nearly a third. Racially the city has diverse residents from Black, White, and Hispanic communities yet fewer Asian and Pacific Islanders. Education rates beyond high school are around 20% and the average monthly rent is over $700 (U.S. Census Bureau, retrieved 2022).

All participants in the study were adults (ranging in ages from 20s-70s) self-identified as transgender and were receiving some form of biomedical gender-affirming care. Participants were excluded if they did not identify as transgender, were under 18 years of age, or were not receiving biomedical care. Nearly all participants were receiving their care in the study location, with the exception of three participants who received their care from other U.S. metropolitan areas, but were connected to the project through contacts to the primary research location. Participants represented individuals from diverse backgrounds of age, race, sex-assigned-at-birth, transgender identity, and education (shown in Table 1). Education level and occupation was gleaned from the participant narratives. Due to the small population, there is risk that identifying specific occupations could lead to participants being identifiable. Participants occupations included being unemployed, students, skilled laborers, service workers, entrepreneurs, and professional workers. Some participants who were experiencing housing instability had to be dropped from the project due to limitations in access for interviews caused by the COVID-19 pandemic and challenges presented by insufficient public transportation and the digital divide.
Participants were recruited through social media posts and via community leaders engaged in the delivery of services to transgender individuals. Community leaders were provided with a research flier that could be sent out to their constituents or displayed in their waiting rooms or bulletin boards. Participants then voluntarily enrolled themselves in the study via an online form that allowed for verification of eligibility in the study. The study recruitment led to 54 potential participants submitting inquiries, of these 28 were recruited into the study. Those not recruited were due to inability of additional follow-up (n=21), inability to participate due to transportation or lack of digital resources (n=4), and one participant was excluded by the researcher due to potential conflict of interest (n=1). Inability to follow-up may have been the result of emails going to a junk or spam folder and not being seen by the participant, in two cases the phone number provided was either incorrect or had been disconnected. Of the 28 participants that began the study 24 completed all parts of the study and 3 completed only the initial interviews and one completed all steps except the final interview. Data from participants who did not complete all parts of the study were excluded. Of the 24 participants most received their care within the study location and 3 reported receiving their care outside of the study location. The participants were all engaged in some level of gender-affirming care that is accessed by both transmasculine and transfeminine individuals: mental health (n=2), endocrinology (n=6), top-surgery (n=2), bottom-surgery (n=4), postsurgical ongoing care (n=10).

Participants were allowed to identify their own gender identity and were not prompted with preconceived categories, as a result participants offered a variety of responses on how they identified their own gender, 13 participants defined themselves
with more than one gender identity category. The gender identities included: woman, man, transgender, trans, transwoman, transgender woman, female transgender, transgender female, transfemme, demigirl, demiboy, transman, transguy, transmasc, transmale, tranny, bigendered, queer, genderqueer, agender, non-binary, and gay. These identity terms will be defined in the glossary. Below is the breakdown of collected participant demographics.

**Table: 1**

<table>
<thead>
<tr>
<th>Participant Demographics</th>
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<td>Total Participants n=24</td>
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<td>30s</td>
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<td>70s</td>
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<table>
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<td>3 Categories</td>
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<td>4 Categories</td>
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<th>Education</th>
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This project uses an actor-network-theory approach to explore the ways in which various human and non-human actors bring together diverse ontological perspectives on what transgender means in order to enact the process of gender-affirming care in the U.S. practices of biomedicine. In order to pull apart this information a review of medical literature was conducted in order to understand the U.S. biomedical systems and practices involved in the delivery of gender-affirming care which can entail mental health services, endocrinology, surgery, other physical medicines, and alternative therapies. Transgender individuals engaged in biomedical gender-affirming care were then recruited to participate in an initial interview, complete a structured journal detailing their next medical visit, and then after submitting the journal complete another interview to clarify and expand on the journal entry. All interview outlines and journal prompts are included in the appendixes.

The pre-medical visit interviews allowed the researcher to get to know the participant and the participant to better know the researcher. These interviews emphasized the participant’s gender identity, decision processes to enter into gender-affirming care, thoughts about the gender-affirming care process, and expectations about their coming medical visit. Some examples of questions that were asked during this first interview were: to detail one’s journey with gender to date; explore causes of gender dysphoria and euphoria; explore how medical information was gained; and explore how a provider was selected.

Participants were asked to complete a structured journal entry immediately following their appointment to record their own experience with the medical visit. The
participant journal entry was used as a guide in the post visit interviews. Additionally, the journal entry served as a means of observing the clinical space, as direct observation by the researcher was not permitted due to COVID-19 pandemic restrictions. Participants were guided to describe the clinical space, interactions with other humans, procedures performed, and their own feelings around elements of the visit. Following the point of care structured journal an open-ended interview was conducted to allow the researcher to explore the journal prompts in more detail.

All interviews were transcribed from recordings, except for participants who did not consent to audio recordings being taken in which case the researcher relied on field notes taken during the interview. During the transcription process proper names such as individuals and places were removed in order to protect participant identification. In these instances, a bracketed word will give context. For example, London as a place would be transcribed as [city] or for names the bracket would contain a relational note to the participant such as [sister] or [doctor]. Following transcription audio recordings were deleted. Participant journals were also transcribed to allow for deidentification of data using the same proper noun replacements mentioned above. Original electronic and hard copies of journals were then deleted or destroyed.

All deidentified data from the interviews and journal entries were then uploaded into NVivo 20, a qualitative data analysis software, to allow for coding and analysis. The data was analyzed using a thematic analysis approach (Schensul and LeCompte 1999, Bernard 2011) which allowed the researcher to pull relevant themes from across participant interviews in order to compare against the current biomedical discourse. Some examples of codes used are: challenges to care; views on letter requirements; views on
WPATH Standards; information sources; provider agreement; provider conflict; and information sharing. Coded data was organized and analyzed along a pattern of the biomedical schedule. Biomedical discourse and practices were compared to patient understanding and experience in relation to different points of care. This organizing of data to look for ontological differences among various practices within medicine is known as praxiography (Mol 2002) and has been used within actor-network theory to organize practices across and within complex systems. Within the practices, I explore the actors both human (patients, providers) and non-human (standards of care, diagnostic tools, treatments, etc.) and explore the ways in which these actors approach a notion of being transgender and bring enactments of these beliefs into the clinical space. By using this method, I am best able to demonstrate the ways in which different ontological notions of transgender enter the clinical space and work both congruently and incongruently to enact the practices of gender-affirming care.

This research was conducted during the COVID-19 global pandemic which had an impact on the research design and the research population, in that direct observations of medical visits were prohibited and in-person contact with research participants was restricted. Ideally, the researcher would have preferred direct observations over the use of structured journals in order to facilitate real-time note taking; however, the structured journals allowed the researcher to understand the elements of the clinical visit that were important to the participants and explore deeper the meanings of these clinical spaces, interactions, and tools for the participants. In addition to not being able to observe the clinical interactions, a number of the interviews occurred virtually to reduce potential direct contact and inadvertent spread of COVID-19, and the researcher was not permitted
to travel to participants, but had to conduct in-person interviews in a specific pre-approved location that met certain distancing and cleaning requirements set by the research institution. The result of this was a lack of housing unstable and lower income participants. Several of these individuals enrolled in the study, but were unable to travel to the approved in-person interview location due to lack of transportation nor were they able to access the virtual meetings due to lack of private computer or internet access. The impact of this exclusion is unknown and could benefit from further analysis in future studies. The final major impact of the COVID-19 pandemic was the delays in gender-affirming care schedules. This was heavily due to hospitals’ intermittent suspension of non-emergency surgical procedures and general employment layoffs and uncertainty which caused some potential participants to delay medical care or cancel procedures. Additionally, the access to individuals early in transition became increasingly more challenging as the pandemic led to the cessation of support groups, or groups were moved to virtual formats that made dropping-in more challenging for transgender individuals just beginning their process to find the groups or participate. As a result, the participants in this study were mainly already engaged in biomedical gender-affirming care or had received the care they desired and were engaged with biomedicine for ongoing or primary care reasons.

This research was limited to transgender individuals who were receiving some form of biomedical gender-affirming care. This is not the only means for enacting gender transition and this study did not recruit for individuals who were not connected to the formal systems of care. This includes individuals who are receiving care through black market or underground channels including injections, hormones, or other cosmetic
procedures. There was some disclosure by participants of accessing these forms of care in the past; it was not the focus of this study and calls for further research into these methodologies and practices, including how those practices borrow from or are structured by the biomedical model, and how they seek to reject elements of that system.
Chapter 3: Background

This research pulls from two established areas of anthropological study, anthropology of gender and anthropology of the body. In this section I will explore the areas of research that influenced and served as background material for this dissertation. Within the study of the anthropology of gender, I will review how non-binary gender classifications were identified and documented, the influence of Western imperialism on some of these classifications, and current works around non-binary gender identities in the U.S. Within the study of anthropology of the body, I will be exploring how the body has been studied as a physical and social object and the ways in which biomedicine has gendered and sexed the body. My research falls within these bodies of literature building on both the study of non-binary gender identities and categories, and exploring the role of biomedicine in (re)constructing identity.

This section will end with a brief history of biomedical gender-affirming care in order to give the reader a perspective on the development of the diagnostic criteria, care standards, and treatment practices.

Anthropology of Gender

Anthropology has played a critical role in documenting societies and cultural systems throughout ongoing Western political and military expansion. Of particular interest to the study of gender was the documentation of third gender categories that did not fit the Western male/man and female/woman classification systems and were either tolerated or given a specific cultural place or role within a society. The use of the term third gender as a means of classification can be a bit misleading as some gender systems allowed for more than three gender categories and the labeling of various classifications
across gender systems into one term can create the potential to attempt to generalize across categories that may be more varied than similar (Towle & Morgan 2006). There are many documentations of third genders such as the: two-spirits of indigenous North America (Goulet 1996, Parsons 2011, Honigmann 1954, Whitehead 1981), fa’afafine and fakaleiti of Samoa and Tonga (Farran 2010, Schoeffel 2014, Semenya 2016, Tcherkezoff 1993), the hijra of India and Bangladesh (Hossain 2017, Mahalingam 2003, Nanda 2014), māhū of Hawaii and the Society Islands (Elliston 2002, Kuwahara 2014), muxes of Mexico (Gómez Jiménez et al. 2020), sworn virgins of the Balkans (Nanda 2014), tombois/toms and Kathoeys of Thailand (Blackwood 2002, Nanda 2014, Sinnott 2004, Sinnott 2011), tomboys of the Philippines (Fajardo 2013), the waria and bissu of Indonesia (Nanda 2014, Huang 2011), among others. Among these populations, the researcher sought to explore the functions or symbolic meaning these third gender categories might hold within the cultural group.

The documentation of these third gender categories in cultures aided in broadening Western understanding of gender by presenting alternative means of constructing and understanding sex and gender. While many of these works sought functional and symbolic explanations, there was less research conducted specifically among the third gender groups as was done among men or women. This is possibly due to the smaller number of individuals who fell into these gender categories.

When it comes to understanding these non-binary gender categories from the perspective of those assigned these labels, anthropological research exploring sexual and gender variance can be found in the more recent cross-cultural work of Evelyn Blackwood’s (2001, 2011) documentation of the tombois of Sumatra, Megan Sinnott’s
(2004, 2011) work among toms and dees in Thailand, and Don Kulick’s (1997, 1998, 2011) ethnographic research with the travestis of Brazil. These contemporary sexual and gender variations are often in conflict with both traditional gender and sexuality concepts and modern LGBTQ expressions and identities. Thus, these serve as an area of interest within anthropology as they tend to paradigmatically represent anti-colonialism and the influences of Western colonialism at the same time.

Evelyn Blackwood (2001) studied female to female relationships across many cultures including Lesotho, Australia, the Kalahari Desert, and Sumatra in order to understand how gender and sexuality influence and impact one another. She critiques how studies of same-sex sexualities are often focused on sex acts and deviance and promotes the inclusion of gender and cultural relativism as analytical frameworks for understanding sexuality across cultures (Blackwood 2002). She also addresses the fact that early research into sexuality and gender often used terminology that was encompassing of both same-sex eroticism and transgender behaviors, a challenge that lingers even today. It is in Blackwood’s analysis of the tombois of Sumatra that she applies some of these methods to explore this sexual and gender category (2011). Tombois define themselves as lesbi (more akin to the meaning of lesbian in the West), yet tomboi childhood narratives are very similar to those of the United States transman, though there is a marked difference in their relation to the body and its subsequent sexed part. While U.S. trans narratives often emphasize a dissatisfaction with the sexed body, (Prosser 1998) the tombois focus more on social and cultural aspects of gender (Blackwood 2011). Interestingly, Blackwood notes that tombois see themselves as men because of acting in masculine ways and gaining social statuses that are often bestowed
to men such as smoking, drinking, and staying out late. The tombois express their body in masculine ways through posture, speech patterns, dress, daily habits, partner choice, among other masculine coded behaviors. While this performance of masculinity gives social access within the community, in kin groups, the tombios often express more feminine aspects to please and maintain harmony within the family. This behavior is extended to close family friends and those who knew the tombois, in childhood. Blackwood attributes these changes in gender expression to the social importance of family units rather than the individual in Sumatran society. This use of gender performativity counter to the gender identity of the tomboi also serves to grant access that men do not have in Sumatra, which is the ability to sleep with and be alone with their female girlfriends. Blackwood here states that she wants to “push theories of gender subjectivity further to think how gendered individuals might take up subject positions that move back and forth across the ideological boundaries of normative sex/gender systems (2011, 219).” A concept that queer theorist J. Halberstam (2005) also points out in A Queer Time and Place; demonstrating that sexual orientation and non-normative gender identity are enacted as coded performances and may change depending on the social situation in which the individual finds themselves. Blackwood (2011) suggests that for identities to exist in the borderlands they must sustain and tolerate contradiction and ambiguity, as the tombois do in expressing both feminine and masculine aspects dependent upon contextual and social situations. For Blackwood (2001), understanding culture is essential for understanding the systems of gender and sexuality that are expressed and the use of ethnography and cultural context are the most productive means of doing this.
A similar gender category can be found in Thailand where Megan Sinnot (2004) engaged in extensive ethnographic work among toms and dees. Toms are individuals whose sex-assigned-at-birth is female, but who dress and comport themselves as men. These individuals do not undergo surgical or hormonal interventions to change their gender, but similar to the tombois of Sumatra, they socially engage with the world as men. Dees are feminine females who are in love with toms. Toms rarely date other toms and dees rarely date other dees. Sinnot explores the ways in which these identity categories are expressed in Thai society, and the way they fit within the broader Thai concepts of gender. Sinnot’s work finds a variety of gender-identity categories in Thailand, and that the separation of gender and sexual orientation are not as demarcated as they are in Europe and the United States. The views heavily mirror those of early 20th Century thought around gender inversion as an explanation of homosexuality (Chauncey 2019, Laqueur 1990). In general Thai culture is fairly accepting of these lesbian relationships, with an expectation that feminine women will eventually forgo these relationships for more traditional heterosexual relationships in the future. This is influenced by the ideas that women who love women and toms and dees who engage in premarital trysts are not at risk for potential repercussions such as unwanted pregnancies. Sinnot cites a great deal of narrative and history that demonstrates the existence of women loving women in Thailand prior to the arrival of Western colonizers, Additionally, Sinnot notes that these identity categories are often viewed as being Western concepts infiltrating Thai culture. This conflict also arises in the relation of toms and dees to the concept of lesbian or women who love women, as many toms do not view themselves as women, but rather as males born into female anatomy. They
contextualize this in Buddhist theology, feeling they were born into this life as a means of resolving conflicts from a previous life. If they were an abusive male, for example, they might have been born into a female body with male psyche to learn how women should be treated. Western Biomedicine has had some recent influence on this narrative as talks of having the wrong hormones are appearing more and more in the younger tom narratives, rather than explanations of rebirth.

Another non-binary gender that presents in a contemporary culture is that of the travesti in Brazil. The travesti is born male and lives in a fully feminine manner adopting women’s dress, pronouns, and mannerisms, but does not identify as a woman or as transgender. Travestis may engage in some body modification yet retain their penis (Kulick 1998). Anthropologist Don Kulick seeks to understand this identity in Brazil by placing it among the local ideologies around sex and gender (1997, 1998). Kulick explores gender in Brazil through the ways in which the travestis enact gender in Brazilian culture and the means for making sense of this gender concept. Kulick notes that, as in much of Latin culture, sexuality is a strong determinant of gender, where a male who engages in same sex relationships, but is not penetrated himself, is still considered straight and male. Kulick finds that this distinction exists also among the travestis who are born male, but live their life as neither distinctly male nor female. Kulick concludes, based on his observations, that Brazil essentially has two genders, men and not men. The distinction is primarily made based on the role one takes in the act of sex. The penetrative, or active partner, is male and anyone who permits themselves to be penetrated, the passive partner, is not male. Kulick proposes that other gender systems can benefit from being explored, not based on their relation to biological sex, but in
relation to the cultural understanding and distinctions for creating gender or gender-near classification systems.

While the travestis are often poor and highly marginalized, Kulick (2011) observes how they use the Brazilian concepts of gender that oppress them as a means of resistance against men who solicit them for sexual favors. The travestis are generally poor and engage in sex work to survive. The men who solicit their sexual services are from across demographic backgrounds in Brazil but are socially higher than the travestis. Three common modes of resisting control and getting back at those in power for the travestis are pickpocketing, assault, and giving a scandal. It is the last of the three that is of most interest, as this involves an “[attempt] to shame a client into compliance with her demands for more money (2011, 301).” This often involves loud shouting, particularly accusing the client of being a disgusting faggot, or detailing submissive sex acts that were supposedly performed by the client. In Brazilian culture, as noted above, to act as the passive partner in sexual intercourse as a man, makes you no longer a true man. These accusations serve to suggest that the men are of lower masculinity than even the travestis, because they would submit to them. These acts often occur outside of the car or hotel room of clients, and often lead to a payment or gift to get the travesti to stop. Kulick notes that travestis try to “conceal the penis (2011, 302),” in daily activities, but, “in scandals the penis is removed from concealment and vigorously brought forth, both linguistically and, sometimes, physically as well (2011, 302).” For this to work the travestis “are purposely drawing on precisely the same kinds of language that are continually drawn on and invoked by others to repress them as homosexuals or transgendered individuals (2011, 302).” Kulick shows that these acts do not seek to
oppose or challenge public attitudes but rather “employ exactly those attitudes in order to
coeerce their clients into acceding to their demands for more money (2011, 303).” The
scandal thus, gives the travesti a level of power in the situation, but in turn also reinforces
the oppressive social understanding of the travestis in the broader culture as violent
sexual deviants.

These three examples show the ways in which analyzing gender and sexuality as
interlocked categories can complicate the understanding of gender systems, particularly
in instances of where transgender or third gender categories are expressed. These models
often appear in conflict with hegemonic understandings of LGBTQ categories and ideas
of local ontologies versus influence from other cultures, particularly Europe and the
United States. Within the study of non-Western cultures, it is important to note the role
that colonialism and Western imperialism, including the Western LBTQ rights
movement, has had on the classification and understanding of non-binary gender
categories both in the U.S. and abroad. Two examples of this are the gender category of
māhū in the Polynesian Islands and the hijra in India and Bangladesh.

The māhū of the Society Islands and Hawaii represent individuals who are born
male and live their lives as women. While there is some reference to female born māhū
who live as men, it is much less common and not as well documented in the literature.
These indigenous identities have come to symbolize cultural heritage and connection to
indigenous cultures. They are increasingly compared against more Western concepts of
nonbinary genders and sexualities among the Society Islands and Hawaii such as the
raerae, petea, and lesbiennes.
Māhū translates to ‘half-man, half-woman’ and represents a person living in a liminal state between manhood and womanhood with elements of both the masculine and feminine in Polynesia (Nanda 2014, Elliston 2002, Kuwahara 2014). The māhū of the Society Islands and Hawaii are generally not considered to have sacred powers, rather they are expected to be adept at traditional elements of society such as hula, indigenous crafts, lei making, chanting and singing. It is this role that the māhū engage with that has led to their importance in contemporary society as a symbol of traditional values in the face of colonialism, particularly from the United States and Japan. The māhū do not engage in sexual relationships with other māhū, but rather tend to seek and find partners whose sex is the same as that which the māhū was assigned at birth. This practice is tolerated within indigenous Hawaiian and Tahitian culture and is socially sanctioned; however, homosexuality and transsexualism are not. When it comes to homosexual identities, Deborah Elliston (2002) notes three other dominant categories, those being raerae, petea, and lesbiennes. Petea are men who are attracted to and have sex with other men and lesbiennes are women who are attracted to and have sex with women. Raerae are individuals born male who adopt European or Western female comportment and attire and may engage in hormone therapies or other means of feminizing the body. All three of these categories are generally regarded with ambivalence or animosity by other Polynesians and stand in contrast to the māhū which is understood to be uniquely Polynesian and rooted in the islanders’ history. The raerae, petea, and lesbiennes are viewed as newer concepts brought into the islands by Europeans (Elliston 2002, Kuwahara 2014). While petea and lesbiennes are specifically concerned with homosexuality, the raerae is more closely similar to the māhū as both are concerned with
gender expressions that are outside of the male/man/masculine and female/woman/feminine. In Tahiti, for example, the māhū is interpreted as traditional and culturally authentic, whereas, the raerae is interpreted as new and inauthentic. Here the raerae comes to symbolize the Western political forces and serves as a reflection of colonial influence (Kuwahara 2014).

The hijra of India and Bangladesh have a long and documented history. The classification of the hijra is varied across India and Bangladesh but generally falls into one of the following categories: a person who was born intersex (formerly known as hermaphrodite), a person born male who has been castrated, or a person born male who is living as a woman (Nanda 2014). The hijra see themselves as closely tied to Hindu deities that are understood to be hermaphrodites, or embodying both aspects of males and females. While they are considered to be among the lower castes within Indian social structures, they often serve religious roles around marriage, fertility, and childbirth.

Modern India and Bangladesh have sought to officially recognize the hijra as a state sanctioned third gender category. The competing local ontologies, religious views, and the influence of the Western LGBTQ rights movement have made this process challenging as Hossain (2017) documents in Bangladesh. Bangladesh officially recognized a third gender category of hijra in 2013. In Bangladesh the hijra is not viewed as part of the Western LGBTQ umbrella. Instead, the hijra are more closely viewed as part of the disabled community, and thus, why they need support. The concept of hijra, as understood by the government, was that of an intersex person, or a eunuch. This was in contrast to the expression of a number of hijras in Bangladesh who retained their genitals. Part of this conflict around the genitals can be understood in the context of Islam, as
practiced in Bangladesh, and cultural views against body modification. Thus, individuals who identified as hijra, but did not undergo castration for religious reasons were seen as being false hijras and seeking to subvert the government authorities.

Across southern Asia (India, Pakistan, and Bangladesh), the hijras represent a government sanctioned third gender with some local variations in expression. The close ties to Hinduism and their existence, both in and outside of the caste and kinship systems, creates a community of interest to scholars exploring gender, and modern revisions to the definition of what makes someone a hijra are becoming heavily influenced by Western LGBTQ ideologies. This changing understanding of gender, and particularly third gender, is also reflected in the fa’afafine and the māhū, all of which are symbolic of a precolonial past and an ever-evolving globalization.

The documenting and study of transgender identities within the U.S. has not been as extensively studied within anthropology, with the exception of non-binary categories within indigenous cultures. While not the primary focus of her work, in Esther Newton’s classic study, *Mother Camp: Female Impersonators in America* (1972), there is mention of assigned-male-at-birth individuals who would likely today be considered transgender. This is most pronounced in her classification of drag performers distinguishing between those who perform femininity on stage and a form of masculinity in the rest of their life, from those who perform femininity in daily life. One of the challenges to studying transgender individuals is the communities are not geographically defined and transgender individuals exist across U.S. culture, a similar challenge to the classification of the gay drag performers noted by Newton. Due to this many studies have centered around support groups where one can gain access to groups of individuals geographically
and socially situated as a unique semi-homogenous community. Much ethnographic research on U.S. transgender populations is centered in New York City, where the population density allows for greater gatherings of minority populations. Anne Bolin and David Valentine both situate their ethnographic work exploring transgender individuals in support groups in the city, though separated in time by three decades.

Anne Bolin (1988) centers her study on gender transition as a rite of passage. This situating of the process makes sense, as there are many rituals and practices associated with sex-reassignment in the United States. The trials and tribulations of that process demarcate a before, intermediate, and after process for attaining a new social status. When exploring the medical system, Bolin examines the role of standards of care at the time and the *DSM* (1980) in the treatment protocols for transgender individuals. She finds that it is in this diagnostic and treatment arena where “theoretical misconceptions”, “stereotypical expectations” and “generalizations” tend to occur. She cautions that mental health providers should look beyond simple diagnostic tools, as their rigidity can problematize treatment. The transgender individual’s experience and narrative may not match directly, but may still necessitate or suggest medical interventions. This is a concern shared by transgender activist and writer, Kate Bornstein (1994), who views the biomedical model as silencing transgender individuals by setting a prescribed narrative and criteria that may not apply to the various expressions of transgender identities. The knowledge shared among the transgender community further embodies the medical discourse and transgender individuals alter their symptomology in order to meet the criteria for treatment. Bolin identified support groups as the primary means of sharing information on the transition process, and the expectations related to interacting with the
medical system (Bolin 1988). Some of the themes essential to the transgender biomedical narrative are a sense of being born into the wrong body, a mirror moment (when the mirror shows an image that is unfamiliar and thus causes distress, typically associated with breasts, hips, genitals, or other external sex characteristics), and hatred of external sex characteristics (Prosser 1998). These narrative episodes serve as the checkboxes for the diagnostic criteria previously established in the *DSM*. Support groups often focused on sharing medical information and tips on passing both as transgender patients and as men and women in the broader world (Bolin 1988). Bolin found that lasting connections were harder to come by due to the stigma of being seen as transgender. Many transgender women, when they had fully transitioned and could pass as cisgender, ceased to attend support meetings and lived on as women, having fit again into one of the gender categories prescribed by the broader community. These notions and patterns may not hold today, as more and more transgender individuals retain their identity as trans following transition for socio-political purposes in the work toward broader recognition and rights.

The transgender narrative is more diverse than just male-to-female and female-to-male, which presents challenges to a system that seeks to reassign-sex, but only offers the outcomes of male/man and female/woman. The increasing political and public presence of those identifying outside of this binary construction has begun to alter the narrative, and continues to raise questions about the current understanding of gender, sex, and sexuality. Ensuring a wide range of transgender narratives will allow for a more broadly conceived understanding, but presents challenges to cisnormative beliefs that are ingrained in our society.
It is around the current gender categories that David Valentine focuses in his ethnography of the transgender community in New York City (2002, 2007, 2011) nearly 30 years after Bolin’s work. Valentine’s entry into the community was through the Gender Identity Project (GIP), a social service organization which held support groups and engaged in street outreach (2007). Through his research he attends various ball scenes, distributes safe-sex kits on the streets, and, like Bolin, sits in on support group meetings. He then engages in formal and informal interviewing with people who would be classified as transgender under the definitions used by the GIP. This definition includes anyone whose gender identity differs from that assigned to them at birth. The definition also delineates gender identity and sexual orientation as two separate categories. Valentine, however, shows how many individuals do not have such clear understandings of themselves within the formal identity definitions, yet fully understand who they are. The defined category of transgender creates challenges both in service and understanding at the same time it creates a community and messaging that can create power and benefits for a traditionally marginalized group of people. The defined categories are often created through embodied and disembodied discourse within a given cultural context (within academia, politics, and healthcare systems) in order to classify at times seemingly disparate individuals. These boxes can create challenges for understanding between service providers and those seeking services when identities conflict.

Valentine explores some of these conflicts within the New York ball scene, a community primarily made-up of queer individuals from communities of color, Black and Hispanic (2002). He states that, “On the whole, butches live in a masculine gender
and take on masculine names; some may take testosterone shots if they have access to them and some have taken fem queens who walk the balls as girlfriends. Fem queens are, to use a similar construction, ‘male-bodied feminine persons,’ although with the relatively easy availability of female hormones and plastic surgery many have feminized their bodies with breast augmentation, electrolysis, and other cosmetic procedures (2002, 228-229).” There are many gender categories at the balls that span the community, but all are united under the umbrella identity of gay, which among the ball goers means non-heteronormative. In this way when the term transgender is applied to these individuals it thus, “includes people who may not want to be included-or indeed may not know they are included (2002, 230).” Valentine notes that, “some transgender activists argue that these individuals are not yet educated into the language of the new transgender movement (2002, 230)” and critiques, “to presume that those not yet educated in the issues are not fully aware of their true identities risks the trap of ‘false consciousness’ and assumes that there is only one way to understand, describe, or experience what may be labeled ‘transgender.’ (2002, 230-231).” Valentine asserts that these individuals are not confused, but reject the separation of their gender identity from their sexuality. For them, both are conceptualized under the auspice of non-heteronormativity encapsulated in their concept of gay and gay culture.

The separation of sex, gender, and sexual orientation into unique categories was an important turning point in the study of gender as a social construct, moving away from the idea of sex and gender as a tightly woven conceptual model where male=man=masculine and female=woman=feminine, and all other models are deviant. Judith Butler (1990) proposed the separation of these analytical categories, which, at the
time, presented challenges to researchers when studying populations where the model did not align or where the model failed to allow for the pluralism present in societies around sex and gender. This model presented sex as a biological and gender and gender expression as social. This analytical framework would lay the foundation for queer theorists who sought to move the modes of analysis away from previously defined categories of gender, sex and kinship and to see analysis of the categories themselves.

Early in *Gender Trouble*, Butler states, “representation serves as the operative term within political process that seeks to extend visibility and legitimacy to women as political subjects; on the other hand, representation is the normative function of language which is said either to reveal or distort what is assumed to be true about the category of women (1990, 2).” The representation defines a community that is not heterogenous and this creates challenges in defining identity within these broader group contexts. Butler explores gender in a way that presents alternatives to the binary, though this work does not focus on transgender populations, nor does it propose to include all gender identities, which she was critiqued for and whose omission she addressed in later works (Butler 2006). However, Butler’s work has served as a foundation for the study of modern lesbian, gay, bisexual, and transgender studies.

The separation of sexuality and gender has been advantageous to the gay and lesbian rights movement, because conceptually they can suggest that sexuality is a private matter and resides in the home, whereas gender is public and thus easier to justify social and political regulation. Valentine gives a call to action to queer anthropology stating that, “If queer anthropology is to address queerness, it needs to examine the underlying assumptions of the categories *gay* and *transgender*, not only cross-culturally but also
within the United States (2002, 240).” While it appears that Valentine is critiquing the separation of gender and sexuality, he declares that there is still value in seeing the two as separate experiences or analytic categories, but cautions that not all conceptual models fit neatly into the categories as distinctly separate (2011). He warns that doing so can lead to the rendering invisible of disenfranchised people, whose voices, views, and identities are and were crucial in shaping their worlds.

Gender is constantly being created and recreated in society, and the modern gender constructions are no different. Analytical categories in gender studies and queer theory divided sex, gender, and sexuality into unique analytic categories. However, the wide range of gendered expressions that fall outside the binary fit along those analytic lines in ways that may present problems in fully understanding how these identities view themselves and are interpreted and viewed by the broader social systems in which they exist. This research contributes to our understanding of these non-binary gender categories, including expanding on the anthropological research focused on U.S. transgender experiences. It also explores how diverse gender categories come together under the umbrella term transgender in order to access gender-affirming care.

**Anthropology of the Body**

Anthropology of the body is concerned with the ways in which the body is understood within cultures and the ways in which bodies communicate various cultural and social aspects, including gender. This communication occurs through movements, adornments, and other performances of bodies within social space. The field has also explored the ways in which bodies interact with medical systems and through these interactions are subjected to normalizing treatments and processes. In this section I will
be reviewing some ways in which the body has been understood, the performance of the self, and the biomedicalization of sex and gender.

The body has been a central object of study in the field of anthropology since the 19th Century (Turner 1991). Over time, the ways in which the body has been studied and understood have expanded as new paradigms and frameworks are applied. This varied look at the body is best summed up in the question presented by J.M. Berthelot (1991) in asking, what is meant by ‘body’? Much of the discourse of the body is rooted in cartesian ideas of a mind/body dualism. This separation of the mind from the body allows one to study the body as an object devoid of thought and sense of being. While this view has led to fields of study such as anatomy, it fails to really explore the ways in which a body exists in the world, often relying on static analysis and structured experiences within medical systems. In order to gain a clear picture of ‘body’, one must recognize that mind/body dualism is flawed (Csordas 1990). John Blacking (1977) states, in his work *The Anthropology of the Body*, that, “The mind cannot be separated from the body (1977, 18).” Csordas takes this further and suggests that one must study the body as being composed of mind, body, and culture; in order to study one, one must take into consideration the role of the others. The focus on the cultural or social body should not be viewed as merely explaining things as culturally or socially constructed and thus not ‘real’ (Latour 2007). Rather, by engaging with the study of the body through the acknowledgement of the mind, body, and social as a whole, one can gain deeper understanding and knowledge (Latour 2007).

The study of the body may be better understood when exploring it from a broader perspective and recognizing the interplay of the mind, body, and the social. Another
aspect of studying the body is recognizing that the tool of analysis is, in fact, the researcher’s own body and mind. When exploring the body within the cartesian understanding of mind/body dualism, this problem is ignored. In studying ‘body,’ one must recognize that the body serves as both an object of study as well as the means of knowledge and the site of the generation of knowledge (Berdayes et al. 2004). Margaret Lock (1993) identifies that the body is both the transmitter and receiver of information. Researchers must account from the role that their own body and experience play in knowledge production and reproduction when studying the ‘body.’

Another challenge to study of the body is defining what one means when they say body or embodiment. John Blacking (1977) encourages researchers to explore the interplay between the physical body and the social when exploring the human body. He explains that because the human organism requires a level of social interaction in order to survive, that the physical body becomes a means of communication and social reproduction. In this way the body can be viewed as an active and dynamic object. J. M. Berthelot (1991) describes the body as a site of interface where lingering dualisms (Ahmed 2004) are brought together. When the social, physical and mind are brought together in the body for study, one can see the ways in which society and culture are reproduced on and within the body. Margaret Lock (1993) notes this, referencing Michel Foucault, in exploring how society creates and defines social status, divisions of labor, and economic status via biopower. She then extends this concept to the realm of biomedicine, where hierarchies of knowledge and social structures are readily visible, to note that biomedicine creates its own objects and then studies them.
This analysis presses the question of just exactly how we should situate ourselves as researchers and the object of analysis when it is the human body. The body has been described as a shifting paradox (Ahmed 2004), which requires a means of analysis that allows for flexibility. The theoretical orientation that is often proposed to accomplish this is that of a phenomenological view of the body (Lock 1993, Turner 1991). Bryan Turner (1991) references the work of Stefan George in exploring a trichotomous view of the person as being comprised of a body, a spirit, and a soul, as creating the foundation from which phenomenological anthropology would be formed. This approach seeks to situate itself in the shifting paradoxes of the body and attempts to address the interplay of conceptual situations of multiplicity and liminality of the body.

For anthropology, the study of the body brings together the micro and the macro level (Blacking 1977). Exploring this convergence of the individual body with the social body, presents a rich array of possibilities for further knowledge. In order to expand our understanding of the body, researchers must understand the role of their own body and the social aspect of fieldwork as it pertains to knowledge acquisition (Ahmed 2004). One possible way of doing this is to include the use of the self as a referent in analysis of data (Berdayes et al. 2004). Berdayes et al. (2004) also suggest that more research could be done into how social configurations and interactions play a role in corporeality. The limits appear to be endless and sociologist J.M. Berthelot (1991) cautions that too much social theory could be placed onto corporeality and embodiment, that is already defined and explained by other theoretical means. Anthropologists should be clear in their study of the body where they draw the lines between the physical body and the social. This appears to be easier said than done as humans have evolved as social beings (Blacking
1977) and thus the divide between natural and cultural is not an easy one to define. The historical placement of anthropology of the body has informed and diverted understanding of the human body in medicine, science, and society.

Mary Douglas (1970) proposed that the physical body is not the only area of embodiment and that the social body is just as important for understanding the embodiment of the individual. Douglas explains that socialization dictates the processes of the body, both natural processes and social practices. According to Douglas, there is a strong social influence on an individual’s consciousness, and how they embody that self through habitus (Bourdieu 1994) and social interactions. These interactions can place one within a specific identity group. For Douglas, the more distant from nature, or natural actions, the more formal a given bodily practice becomes. The human social system thus, appears to place a social value on the control of bodily functions. As a result of this interplay between the social and the physical, Douglas asserts that there are essentially two bodies, the physical and the social that lead to individual embodiment.

The outward expressions and embodiment of the self appears to be a human universal, as every known culture engages in some practice of bodily modification or adornment practice, that serve non-physiological purposes. Andrew Strathern (1977) poses the skin as the outer-self and serving as the immediate point of contact between the individual and the outside world. For Strathern, the skin becomes the location for the interplay between the self and the social forces around an individual in a social system. Terrance Turner (1980) also locates the boundary between the biological and the social self onto the skin and hair. For Turner the skin is where the, “drama of socialization is enacted (1980, 486).” This enactment takes place through adornment and modification.
According to Turner, adornment of the body acts as a pseudo language with deep and rich symbolic power, this he concludes, makes the physical human skin become a tool of social interaction which he labels the *social skin*. The movement toward studying the body as both a physical object and a social or symbolic object created an understanding of another dualistic body, but advancement into other facets of bodily exploration opened this inquiry even further as the body, and the means of studying it multiplied.

Bodies become enacted through experience and social interactions with other individuals in groups, but they also enact, are acted upon, and shaped by larger political and economic factors. Nancy Schepers-Hughes and Margaret Lock (1987), explore the body as comprising three domains: the body-self, the social body, and the body politic. While exploring the body-self as a holistic mind-body unit, the social body demonstrates the ways in which self-identity changes with the social and political context across hierarchy and time. This impacts body image, especially in relation to the body’s existence and interaction in the world around it. The body politic focuses on the body in society, in relation to power and control, particularly what bodies are seen as healthy, fit, normal, or powerful versus the rest.

Annemarie Mol expands on the multiplicity of the body in her work *The Body Multiple* (2002), where, by taking an actor network theory approach to exploring atherosclerosis, she uncovers a wide range of embodiments of the disease and means of interacting and understanding the condition. Patients, doctors, pathologists, surgeons, and physical therapists all exist within the network of care for an individual with atherosclerosis, but all have different understandings, ways of knowing, and means of interacting with the body. In addition to recognizing the impact of the body social, by
applying the concepts within actor network theory, Mol explores the ways in which tools, medication, and the body physical interact to inform the ontology and epistemology around the biomedical treatment of atherosclerosis. We learn from her research that the social body can also include interaction with natural and man-made objects in addition to interactions with other individuals, and cannot be discounted when exploring the meaning and experience of embodiment of the human body. This inclusion of non-human actors reveals the ways in which the body moves through different settings informing and being informed by those scenes (Shepherd 2004).

Sociologist Erving Goffman (1959) in his work, *The Presentation of Self in Everyday Life*, explored the ways in which individuals act-out their identity to others, and the ways in which setting, time, and actors can alter the presentations and interpretations of the individual. Francis Huxley builds on Goffman’s work stating that, “the body is then not just a vehicle for meaning but the instrumentation of the symbolic awareness (1959, 29).” For Huxley, the setting and material items within can greatly influence the actions undertaken and that the symbolism of the material objects present in the scene are also at play. This attempt at a holistic view of social interaction seeks to understand the nuanced meaning present. Huxley also explores the rites within a society and suggests that some acting of identity is based within the collective group, rather than individual actors. He also notes that the symbolism is held across the group including the understanding of ritual objects, which he notes are often not described using terms of the effects they produce on the body. This symbolic presence of objects is explored in the birthing process enacted by Indonesian midwives and the presence of obstetrical scissors by Vanessa Hildebrand (2012). For these midwives the symbolism of the scissors as a
tool of biomedicine and power is more center stage than their role in actual medical or child delivery practice. These symbolic actions and objects are not universal, and Huxley notes that they require a particular scene for the action to be taken. This scene only exists due to the political and economic reforms to the practice of medicine and childbirth in Indonesian society. This performative version of the body and embodiment is explored as a social and cultural construction. Terence Turner (1984) cautions researchers around defining the body as social and losing sight of the physical body and its processes. For Turner, this distancing could lead to studies of body and embodiment that are devoid of a tangible subject. The question he poses is where one should draw the line between that which involves the body and that which only involves the social.

Thomas Csordas (1993) explores bodily performance, wherein the focus is on processes which he calls *somatic modes of attention*. He describes these as, “culturally elaborated ways of attending to and with one’s own body in surroundings that include the embodied presence of others (1993, 138).” The somatic modes of attention, for Csordas, are culturally constituted, rather than being determined by biology, and can serve as a means of interpreting culture through bodily practices. Csordas even suggests that researchers consider revisiting previously analyzed data and examining it through the lens of somatic modes of attention to seek additional meanings from their ethnographic data. There is still a great deal of diversity in how to navigate the boundaries between the social and the physical body. Chris Shilling (2005) summarizes the future of the body in sociology and other social sciences as allowing for research into, “how the body might be considered to be a productive creator of society, to be shaped, constrained, inscribed or
enhanced by society, and finally, to be affected by the actual outcomes which result from interaction between body and society (2005, 72)."

In all this study of the body, the central theme is embodiment. How are the experiences of being human manifested in and on the physical person. According to Thomas Csordas (1990), by recognizing the faults and limitations in cartesian dualistic views of the body and exploring the interplay of mind, body, and culture, we can gain a deeper understanding of the body and shift our focus from just the physical to the processes of the mind and body together. Within these attempts to conceptualize and compartmentalize the body, the mind, and society, also fall the divisions proposed to the categories of sex (body), gender (mind), gender expression (social), and sexuality (overlays of several of these categories). It is in this framework where explorations into gender and sex categories demonstrates the diversity of categories and behaviors beyond binary concepts of male-men, and female-women.

Atwood Gaines (1991) describes Western Biomedicine as a form of ethnomedicine which is focused on Western cultural values. For Gaines this positioning is important in identifying the techno-scientific practices of Western Biomedicine as a form of cultural construction, rather than removed from social, political, and cultural influence. This is highlighted with the description of medicine’s move toward the technoscientific, outlined in *The Birth of the Clinic* by Michel Foucault (1994). In this work, the author relates the history of the development of modern biomedical practices as one of distancing the person from the body in order to view bodies as the object of medical study and discourse rather than social individuals. This view of persons as bodies, or rather bodies as objects, was coined the clinical or medical gaze and influenced
the ways in which patients and providers interacted in clinical or healing settings. During this shift, biomedicine became more formalized and universalized in practice through standardized education and the establishment of regulatory bodies and practices. It also regulated the types of persons who could engage in the practices of medicine. From the public perception, in these cultures, the practice of medicine became one where medical providers were well educated individuals with the ability to cure and resolve problems of the body and non-normativity of individuals or groups. These changes were part of a broader social shift that led to a valuing of education, innovation, and capital over experience.

David Armstrong (1983) examines the ways in which medical technologies have altered the ways in which medical practitioners examine and view the body and its composite parts. The ability to see deep into the body and its systems allowed the medical gaze to be a penetrative gaze to the deepest recesses, and eventually the smallest components of the body. Armstrong states that, “the reality of the body is only established by the observing eye that reads it (1983, 2).” This interpretation of the body places a heavy emphasis on the anatomical body as a series of parts and systems to be studied, explored, and treated. The medical gaze seeks to be objective and often denies the body of a social existence, but it is through medical interaction and interpretation, that the body gains meaning in biomedicine. In exploring these meanings and power structures, the social scientist can evaluate how the medical gaze serves as a tool of surveillance, inspection, and judgement to evaluate status and function. The separation of the body from the social as a means of study, allowed for concepts of uniformity and the belief in a universal and fixed human biology. Medical providers became experts,
and patients are moved from their natural environment of the home to purported neutral environments within the biomedical system, in hospitals and doctor offices. This distancing of the provider from the patient is increased by the tools that are used within the medical setting.

There are a number of positive reasons for the clinical gaze. One being the ability to perform interactions on and in the body of another, that would generally be socially unacceptable, such as surgery. However, there are some challenges presented by viewing the body as a physical object detached from social and political existence. This can best be observed when working with clients from traditionally marginalized populations in a society. William Robertson (2017), observes this in patient/provider interactions among lesbian and gay patients and lesbian and gay medical providers. In these clinical settings, the shared social situation of being from a minority group did not lead to better understanding of unique medical needs, rather the medical providers had been trained not to bring personal life into the clinical setting. Thus, they did not discuss sexual orientation with their patients. The training to enact the clinical gaze, acquired during medical school, created a divide between the provider and patient that did not allow for a more holistic approach to medicine that could lead to better health outcomes for lesbian and gay patients. It is this distancing of the patient as a person from the patient as a body that creates the guise of objective intervention and treatment, but also blinds the provider and patient to the role that social and cultural influences can have on health and wellness. Byron Good (1994) explores the means in which Biomedicine views the body as a biological object in order to conceptualize disease as a physicality. Through medical training, one learns to view the body differently and this enables a new set of normative
interactions to be socially and culturally permitted. This medicalization and objectification comes with a new technical vocabulary that serves as a sort of ritualized marker of one’s attainment of medical knowledge and the practice of said knowledge. This knowledge is then shared among other practitioners using the internal technical language, that may not easily be understood by those not initiated through formal biomedical training.

When it comes to the care received by queer patients, there are many conversations that are beyond the clinic walls. These include a broad social conversation regarding the valuation of queer lives across politics, education, employment, and public accommodations. In *The History of Sexuality*, Michel Foucault (1980) details the ways in which governments and societies express biopolitics, which are policies and practices that regulate elements of the human body and bodily practices, including gender and sexuality. For Foucault, the purpose of the biopolitics was to control individual citizens for the benefits of those in power. In capitalist societies this means maintaining control and regulation over the modes of production and workers. Judith Butler (1990) pulls heavily from Foucault in her analysis of the ways in which gender is regulated through policy to maintain a masculine power and a feminine subservience through biopolitical regulation of production and reproduction. Biopolitics also extends into the realm of those seeking to change genders (Butler 2006). In the West there is a formal structure and process for an individual to undergo a gender transition, generally from male-to-female or female-to-male. The history of this process and the associated diagnostic requirements to access transition-related-care are paralleled heavily with the women’s rights movement and the queer liberation movements in the United States and Europe. The process has
gone from one that was more or less focused on social role to one that is dictated by biomedical intervention and state documentation. These dictates are often framed on the dominant cultural narrative of transgender individuals being seen as transitioning from their sex-assigned-at-birth to the opposite sex category, with an emphasis on maintaining a male/female binary gender categorization.

Transgender bodies and individuals are subjected to biopolitical control through regulation against changing gender markers on identification documents, mismatch letters from Social Security when seeking employment, sex-segregated facilities (housing, schools, prisons, etc.), and even medical interventions. The background of medical practices related to transition in the United States will be explored more fully later in this chapter. However, the tools of biomedicine that seek to regulate and standardize gender-affirming care are established practices that often lack the direct voices of transgender individuals and are created and recreated by the dominant group (academics and medical providers) and applied to the subordinate group (transgender and gender variant individuals). These tools include the *Diagnostic and Statistical Manual of Mental Disorders* (1980, 1987, 1994, 2013), *International Classification of Diseases* (Who 1993), and the *World Professional Association for Transgender Health’s Standards of Care* (Coleman et al. 2012, 2022). In addition to these tools, insurance markets, hospital protocols, and knowledge and skills of medical providers all shape the ability of transgender individuals to access appropriate gender-affirming care. These tools and regulations are directly linked to the ways in which medicine has interpreted sex, gender, and the body.
Alice Domurat Dreger (2007) looks at the role of modern science and scientific discourse as it relates to individuals with atypical anatomies, particularly focusing on intersex individuals and conjoined twins. She traces the historical appearance of these bodies on display for universities and medical institutions that were theatrical in nature and afforded a means of income for the person of atypical anatomy to survive. During this era, the experience and personality were still very much a part of the medical discourse surrounding their atypical anatomy, and while the lens was often one of curiosity and voyeurism, the individual was very much present. Today, these individuals are often reduced to body parts or the anomaly only and rarely benefit directly from research and display within medical institutions of their bodies and organs. This process tends to create a power dynamic between the medical professional and the atypically bodied person where the medical professional appears to have a right to that person’s body and the knowledge to be gained with only the incentive that it will help future individuals to be normalized. This, Dreger notes, “construct[s] the patient as the unauthoritative ‘needy’ (2007, 484).” The medicalization of atypical bodies has distanced the lived experience of these individuals from the medical narrative. It further perpetuates the freak show aesthetics of shock and intrigue, only masked under the guise of scientific advancement, and often primarily accessible to normatively bodied medical professionals. In *Intersex in the Age of Ethics*, Domurat Dreger (1999), challenges the medical gaze suggesting that patients should be seen as people, rather than body parts and objects needing corrections without due patient input. This raises the question of how medical providers can incorporate the lived experiences of patients in clinical practices,
and how much choice should patients have in navigating decisions about their body and proposed corrections to be enacted thereon.

For many transgender patients, gender-affirming care is an important part of altering the social body in order to move through society and communicate their identity in a more authentic way. The process of attaining a diagnosis gives one access to the system for a medical transition, but the individual is also undergoing a social transition among friends, family, and their community. Harold Garfinkel (1967) is an early researcher into gender transitions and offers an account of his work with a supposed intersex patient, Agnes, who is seeking to have their biological sex reclassified to fit with their gender identity. Garfinkel explores Agnes’s genitals from the perspective of having a penis or vagina as a biological event and having a penis or vagina as a cultural event (in this case medically created or man-made). The having of the expected sex characteristics allows the individual to be perceived as normal, or abiding by the social ideas. Garfinkel demonstrates how ingrained the concepts of the sex/gender binary is, stating that, “wherever there are cases of males with vaginas and females with penises there are persons who, though they may be difficult to classify, must nevertheless be in principle classifiable and must be counted as members of one camp or the other (1967, 126).” In these cases, Garfinkel suggests that a surgeon serve to correct where nature erred and to legitimate the sexual identity of the individual. Garfinkel also explores the social role of passing and the acquisition of normative behaviors and gestures that pertain to the individual’s sexual identity. Garfinkel’s work was ahead of its time, and his arguments for sex-reassignment have led to the current biomedical model used in the treatment of gender dysphoria today. However, he was also critical of Agnes, suggesting that she
tricked him by presenting as intersex, when she was really what today we would classify as transgender. She did this by acting feminine and secretly was taking female hormones that had been prescribed to her mother. This framing of Agnes as misrepresenting herself in the face of medical authority is explored in the independent film, *Framing Agnes* (Joynt 2022), which explores the transgender and gendered lives of Garfinkel’s patients from a transgender perspective, rather than solely a medical gaze. This allows for a thicker understanding of the ways in which non-binary genders may have been represented during a time prior to the standardization of treatments and diagnostic criteria for transgender individuals. The film ties both the past to the current states of gender-affirming care and the primarily cisgender gatekeepers of the gender-affirming care process by engaging in dialogue with the transgender actors portraying Garfinkel’s patients.

Garfinkel’s research is also dated and not without critique. Twenty-five years after the article’s publication, Mary Rogers (1992) presents a feminist critique that Garfinkel falls short in his research with Agnes by not exploring the ways in which gender is socially produced in the research setting between the male researcher (Garfinkel) and his female participant (Agnes). Rogers reevaluates Garfinkel’s research seeking to explore the ways in which Garfinkel and his own gender expression served to both validate and support Agnes’s gender identity. She also critiques the role of Garfinkel as a gatekeeper to Agnes’s access to gender-affirming care, and whether he can truly be an objective ethnographer in this situation. In presenting these questions, Rogers raises the point that all characters in the research including researcher were performing gender and seeking to pass. All people perform gender to some extent, Rogers suggests
that cisgender people also perform gender and pass in gender roles. Roger’s conclusion was challenged by Don Zimmerman (1992) who argues that cisgender people cannot pass because in order to pass one must be passing for something they are not. I reject this semantic argument from Zimmerman, and suggest that we all seek to do gender, and in doing so are thus seeking to be perceived and pass for the gender role we are intending to, even if culturally expected based on sex-assigned-at-birth. Garfinkel relied on both biological elements and social expectations or behaviors, however, it was the social behaviors which carried the weight in his decisions around patient care.

Most recently, anthropologist Eric Plemons’s work The Look of a Woman (2017) pulls apart the practice of facial feminization surgery, which is conducted to make masculine faces appear more feminine. While these procedures are often entered into with the intention to help transgender women pass as cisgender women, the results can vary. Plemons points out that many of these procedures are being conducted in private medical facilities and often have a heavy focus on White Western beauty standards. He also explores the ways in which gender, providers, clinics, nurses, patients, and procedures interact to enact facial feminization surgeries and their intended outcomes. Plemons demonstrates the importance of care and the meaning of medical intervention for transgender individuals, however, due to the limited scope of procedures explored, there is no representation of transmasculine patients in the work. Additionally, many of the individuals engaged in these practices have access to capital in order to pay for these treatments. For some, this outward appearance is essential for their day-to-day performance of gender.
My research situates itself within this literature by building upon the explorations of the social body and the biomedicalization of gender by exploring the ways in which transgender patients navigate accessing gender-affirming care and the social interactions with the care, provider, clinical staff, and treatments. The findings explore how multiple understandings of the sexed and gendered body from patients and providers are brought to social interactions within the clinical space in the enactment of gender-affirming care.

**History of Biomedical Gender-affirming care**

Gender-affirming care is a series of cultural practices in the United States which seek to make the physical body more congruent with one’s gender identity when the sex-assigned-at-birth and the cultural gender expectations do not align along a male/man and female/woman binary. Gender-affirming care is sought by a variety of transgender individuals including those who identify as transman, transwoman, transmasculine, transfeminine, genderqueer, or non-binary among other labels. A transgender individual does not necessarily need to engage in gender-affirming care, but may engage in some elements of care during their lifetime when the broader cultural expectations or actions toward the individual cause distress, or dysphoria.

This section will give an overview of the biomedical advancements, changes in regard to the identification, and gender-affirming care practices enacted on transgender individuals that have been the impetus for our current diagnostic tools and standard care practices.

Magnus Hirschfeld is held as one of the earliest adopters of medical interventions seeking to treat transgender individuals, which at the time were classified as transvestites or homosexuals. Hirschfeld founded the Institute for Sexual Research in Berlin and was
influenced by endocrinologist Eugen Steinarch in developing affirming treatments for homosexuality and transsexuals (Dose 2014). It is through Hirschfeld’s work in Berlin that he developed adaptation therapy which framed the challenges to homosexuality, and transsexuality, as not pertaining to disease, but rather as a social or of unknown biological origin (Dose 2014), thus necessitating supportive treatments and counseling rather than corrective treatments focused on making an individual heterosexual or cisgender. He also classified these expressions of human sexuality as pertaining to four main areas of sexual intermediacy “sexual organs, other physical characteristics, sex drive (sexual orientation), and other psychological characteristics (2014, 68).” Hirschfeld was an activist and supporter of queer individuals including those who were transgender. He would also propose that transgender was a separate category from homosexuality (Hirschfeld 2006) and would serve as an influence to future medical professionals in disentangling gender from sexual orientation. Hirschfeld was known for hiring patients to work in his office as employment opportunities (Bevan 2019). Then, as well as today, employment presents challenges to transgender individuals due to societal discrimination. It is believed that Hirschfeld conducted the first genital transformation surgery on one of his staff, Dora Richter, in the 1920’s (Bevan 2019). Unfortunately, much of Hirschfeld’s research would be lost due to the nature of the work at the Institute for Sexual Research and Hirschfeld’s identity as a Jewish and gay man when Nazi sympathizers destroyed the institute and its records (Bevan 2019).

Lili Elbe is one of the earliest transgender individuals to receive sex-reassignment surgery, and in doing so become an early media sensation. She would later die following a subsequent surgery seeking to implant a uterus, which her body rejected. While the
clinical records of her transition have been lost due to allied bombing during the war, her story was documented in an autobiography, *Man into Woman*, compiled and published after her death by Niels Hoyer (1953). Sandy Stone in the essay, *The Empire Strikes Back: A Posttranssexual Manifesto* (2006), notes that due to *Man into Woman’s* introduction being written by British sexologist Norman Haine the work was elevated to being “a semi-medical contribution (2006, 233).”

One of the most prominent cases of transition in the mid-Twentieth Century was that of Christine Jorgensen, whose social and medical transition was heavily documented by the media during her time. Jorgensen’s transition was sensationalized in the media due to her identity as a male member of the U.S. military who traveled to Europe and returned as a blonde beauty. While her autobiography, *Christine Jorgensen: A Personal Autobiography* (2000), and personal stance were to distance herself from other transgender, transexual, and homosexual individuals she became a beacon of hope for many seeking to follow in her path of self-actualization (Hausman 2006). Post-World War II seems like an odd time for gender reassignment surgery to be dominating headlines and attracting attention that raised Jorgensen to a state of celebrity. However, as historian Joanne Meyerowitz explains in the article *Transforming Sex: Christine Jorgensen in the Postwar U.S.* (Meyerowitz 2006), the symbolism of Jorgensen’s transformation was one of conquest over nature and fate, where science and technology would lead the way to solving domestic and international challenges as well as launch a new era of advancement.

One of the greatest influences on gender-affirming care in the U.S. was that of Dr. Harry Benjamin. Dr. Benjamin is known for several crucial contributions to gender-
affirming care and understanding of transgender individuals. His book *The Transsexual Phenomenon* (1966) is still considered one of the foundational texts of gender-affirming care. As will be discussed later in this paper, the aptly named Harry Benjamin Standards of Care would serve as a guide for practitioners for decades and grow eventually to become the currently followed World Professional Association for Transgender Health Standards of Care. Benjamin was trained in medicine in Germany and worked closely with Magnus Hirschfield and Eugen Steinarch, learning from and building upon their work related to the biomedical manipulation of sex and gender through hormone treatments and surgical interventions. He moved to the U.S. prior to the first World War and through connections with sexologist, Alfred Kinsey, began to interact and work with transgender individuals seeking gender-affirming care (Stryker & Whittle 2006).

When it comes to genital surgeries, while castration was a practice performed for centuries in human populations, Harry Benjamin noted that, “We must remember, of course, that castration produces a eunuch and not a woman (Benjamin 2006, 52).” In this way the interventions performed on transgender individual’s genitals would require more than just the removal of gonads of external sex organs. It should be noted here that while transgender individuals assigned-female-at-birth are mentioned in the early literature, there is little discussion of these categories in regard to gender-affirming care and the primary focus is on individuals assigned-male-at-birth (Hirschfeld 2006, Benjamin 2006). This necessitated the development of procedures to construct a functional neovagina. The primary challenge in creating the neovagina is determining the biological tissue to be used in the internal construction. The aforementioned Christine Jorgensen received her vaginoplasty through the use of a full thickness graft of the penile skin. A procedure
performed by surgeon Paul Fogh-Andersen (Monstrey, Selvaggi, and Ceulemans 2007). In 1956 Dr. Georges Burou “invented and applied the anteriorly pedicled penile skin flap inversion technique” this would be a procedure that he would perform over 3000 times before presenting about the technique at the Stanford University Medical School (Monstrey, Selvaggi, and Ceulemans 2007). This technique utilizes the skin of the penis shaft as material for the construction of the neovagina. This technique of penile inversion is still the most commonly practiced technique for gender-affirming care vaginoplasties and for decades was considered the gold standard. That designation will be reconsidered later in this section with the current application of the peritoneal pull through procedures being adapted for gender-affirming care.

Early medical clinics performing vaginoplasties for transgender patients included the Johns Hopkins Medical Center, as well as hospitals in Stanford and Chicago. The Johns Hopkins doctors began the practice using partial thickness skin grafts but would eventually switch to the full thickness penile skin grafts to construct the neovaginas (Monstrey, Selvaggi, and Ceulemans 2007). Johns Hopkins would then adopt the use of a posteriorly pedicled penile skin flap inversion technique in the late 60’s (Monstrey, Selvaggi, and Ceulemans 2007). Today, various techniques for lining the neovagina are used across the U.S., including “nongenital skin grafts, penile skin grafts, penile-scrotal skin flaps, nongenital skin flaps, pedicled intestinal transplants (2007, 120),” and the peritoneum. Most are variations on these early techniques and their use is determined by the surgeons, hospital systems, and patients.

Surgical advancements, while less well documented in the media, were also occurring in regard to phalloplasty. Laurence Michael Dillon is the first documented
individual to receive a successful phalloplasty and this procedure was performed by Harold Gillies (McInnis 2022). Gillies developed his procedure for phalloplasty following his work as a plastic surgeon working on injured soldiers through the World Wars (McInnis 2022). In this procedure, performed on Dillon, a pedicled skin flap from the groin and pelvic area was used to construct the penis and the urethra was elongated in order to allow for urination from the tip of the penis (McInnis 2022). This procedure required 13 surgeries performed in 5 stages from 1946-1949 (McInnis 2022). The procedures for phalloplasty have remained relatively unchanged through to today, though various skin grafts are also used to form the penis. Tissues to create the neopenis can be harvested from a variety of locations including the inner thigh, though skin tissue from “the radial forearm is universally considered the ‘gold standard’ in penile reconstruction (Monstrey, Ceulemans, and Hoebeke 2007).” Phalloplasty procedures remain challenging due to aesthetic and functional issues that biomedical science has yet to address. As a result, transgender men may not seek genital surgeries beyond hysterectomy, or may opt for less complex procedures such as metoidioplasty. Metoidioplasty involves lengthening and straightening an enlarged clitoris in order to construct male genitals. Metoidioplasty is a term that was coined by Lebovic and Laub who derived the term from the Greek *meta* meaning change and *oidion* meaning female genitals (Lebovic and Laub 1999, Bizic et al. 2021, Schecter 2017, Hage 1996). The procedure as, described by Hage, is an alternative to phalloplasty which may include clitoral release, movement of the urethra to the neoglans, vaginectomy, and possible scrotoplasty (Schecter 2017, Hage 1996). In *Surgical Management of the Transgender Patient*, Loren S. Schechter (2017) notes that the procedure will allow an individual to urinate while standing, but will be unlikely to
result in the ability to engage in penetrative sexual intercourse. The procedure also can be converted to a phalloplasty should the patient desire that in the future.

Advancements in gender-affirming care, particularly surgical interventions, spanned several decades and on April 17, 1979 a letter was issued on University of Texas, Medical Branch stationery which declared the founding of the Harry Benjamin International Gender Dysphoria Association (HBIGDA 1979). This new organization would focus on research and bringing together providers of gender-affirming care, continuing and building upon the work of the Janus Information Facility funded through the Erickson Educational Foundation (HBIGDA 1979). This program was established and funded by Reed Erickson, who was a trans man and philanthropist (Janus Information Facility 2012), to broaden understanding and information on transgender issues. The Harry Benjamin International Gender Dysphoria Association would establish the Standards of Care for gender-affirming care. Much of the early work to establish standards of care was heavily influenced by the work of Harry Benjamin, whose 1954 article laid out his clinic observations and proposed standards for diagnosing and treating transgender patients (Benjamin 2006). Benjamin’s early suggestions for treatment noted that psychotherapy meant to cure through conversion therapy methods was “a waste of time (2006, 52).” Benjamin recognized the importance of surgical interventions for transgender individuals and the high risks for self-harm, depression, and suicide. Benjamin in this early article promoted surgical intervention as the “lesser evil” to non-intervention and that “we [medical professionals] may have to accept this chance as a calculated risk (2006, 51).” Benjamin would declare that a psychiatrist should have the authority to determine if hormonal or surgical interventions are necessary. This step has
stood as part of the WPATH Standards of Care to date (Coleman et al. 2022), and is one of the main contestations against the standards of care by transgender patients. The general process of a mental health provider signing off on procedures, followed by hormone treatments, and then surgical interventions, remains the primary track that the Standards of Care supports and is practiced by medical systems providing gender-affirming care in the U.S.

The Harry Benjamin International Gender Dysphoria Association would later become the World Professional Association for Transgender Health (WPATH). Over the years, the organization has updated their Standards of Care with versions being produced in 1980, 1981, 1990, 2002, 2011, 2012 and 2022. The WPATH Standards of Care Version 8 (Coleman et al. 2022) was just released and the implications on care are yet to be determined, as other systems such as hospital practices, diagnostic criteria, and insurance company requirements will have to navigate whether to adopt or reject the recommendations. Some notable changes to the Standards of Care version 8 (Coleman et al. 2022) include: increased information on treating adolescents; the suggested reduction of two clinical letters to one supporting gender-affirming care; the removal of a minimum age requirement to start gender-affirming care; decreased requirements for hormone therapy before surgery; removal of requirement to live in chosen gender before medical intervention; increased inclusion of non-binary gender identities; and the inclusion of eunuchs (Coleman et al. 2022). These changes appear to be addressing some of the critiques of the previous versions, where gatekeeping by medical requirements has been a constant challenge for seeking and obtaining gender-affirming care. It also appears to be
broadening the definition of who qualifies as transgender and deserving of care as non-binary gender identities continue to increase in the U.S.

In the United States, the DSM is the primary diagnostic tool for mental disorders and is produced by the American Psychiatric Association. The first appearance of diagnoses for gender identity disorder appeared in the DSM-III (1980). Beek et al. cites increased societal awareness of transsexualism through visibility of celebrity figures, like Christine Jorgensen, and the availability of sex-reassignment surgery as a reason for this increased focus on gender incongruence as a mental disorder. They also pointed out that, “it was acknowledged that sexual orientation and transvestism had to be distinguished from transsexualism (as it was then called), and in 1975 and 1980 transsexualism was included in the ICD-9 and DSM III, respectively (2016, 6).” In the DSM-III disorders that would pertain directly to transgender individuals were transsexualism, gender identity disorder in childhood, and atypical gender identity disorder all classified as psychosexual disorders (Beek et al 2016). Seven years later, in the revised DSM-III (1980) (DSM-III-R (1987)), atypical gender identity disorder would be replaced by gender identity disorder not otherwise specified and gender identity disorder in adolescents and adults non-transsexual type. These diagnoses would all be classified under sexual disorders and further classified as disorders usually first evident in infancy, childhood, or adolescence (Beek et al 2016). The DSM-IV (1994), published in 1994, included gender identity disorder in adolescents or adults, gender identity disorder in children, and gender identity disorder not otherwise specified all under the category of sexual and gender identity disorders (Beek et al 2016). The most recent revision of the DSM was conducted in 2013 and released as the DSM-V (2013). In the DSM-V, gender
identity disorder was removed as a diagnosis and replaced with gender dysphoria in adolescents or adults, gender dysphoria in childhood, other unspecified gender dysphoria, and unspecified gender dysphoria all classified under the category of gender dysphoria (Beek et al 2016). Looking at the types of classification and category changes provides a reflection into the understanding and acceptance of transgender and non-binary gender identities within the practice of psychology and psychiatry in the U.S.

One of the biggest challenges to accessing gender-affirming care procedures in the U.S. is cost. Until recently many private insurance companies declined to cover gender-affirming care procedures, initially classifying these procedures as cosmetic. Then, following a 1979 court ruling in Davidson v. Aetna Life and Casualty Insurance Company (1979), explicitly stating that gender-affirming care or transition-related procedures were not covered (Plemons 2019). Today more and more private insurance carriers are covering gender-affirming care due to demand from corporations focused on recruiting, retaining, and diversifying their labor force. This has also been heavily driven by the Human Rights Campaign, which began to score corporations and employers on its Corporate Equality Index (Human Rights Campaign 2022) by tracking and rating LGBTQ inclusivity policies and practices, as well as greater public support for the LGBTQ community. A major turning point for coverage of gender-affirming care, and a cause for the apparent increase in demand for these procedures, occurred in 2014 when Medicare removed its exclusion to gender-affirming surgeries (Plemons 2019). This has created better financial access to lower income individuals, a challenge faced by many transgender individuals as a result of family rejection and discrimination in housing.
education, employment, and public accommodations. Despite these changes, insurance coverage, policies, and financial costs related to gender-affirming care remain barriers.

One of the newest surgical procedures being practiced for gender-affirming vaginoplasty is the peritoneal pull through, or the Davydov procedure. While this procedure has been performed on cisgender women for decades, it has only recently begun to be performed on transgender individuals in order to construct a neovagina (Suwajo et al. 2020). This procedure uses the peritoneum in order to construct the neovagina, a deviation from the current standard use of the penile inversion. Due to the newness of this procedure’s application to gender-affirming care, most information is available for cisfemale patients aside from case studies for transwomen. The procedure appears to be of symbolic importance for transgender women and will be explored in chapter eight.
Chapter 4: The Biomedical Schedule

The findings of this research will be presented in the order of the biomedical schedule (see figure 1 below). At the start of each section, I have included an ethnographic vignette from one of the participants in italics. All names of participants and locations are pseudonyms to protect participant confidentiality. Transgender patients experienced a variety of interactions with providers and medical systems. The vignettes were selected to highlight common experiences or interactions, but are not representative of all transgender patients. Additional participant quotes are included in the presentation of the findings within each chapter.

Trig is a Black transmasc demiboy in his thirties. Trig knew that he wanted top surgery to contour his chest into a more masculine appearance. He went to General Hospital having learned from other transfolk that the hospital used an informed consent process and they wouldn’t “have to jump through a bunch of hoops” to get on hormones which he knew were a prerequisite to top surgery. He was not interested in engaging in hormone therapy but knew that not doing so would be a barrier to accessing the gender-affirming top surgery that he desired. Prior to starting hormones through the hospital, Trig had started on hormones through the black market by purchasing testosterone from the Internet and using it unmonitored. When Trig did go to the clinic, it took two weeks for him to get his prescription and start hormone therapy formally through the biomedical system. Trig had to be on hormones for one year before he would be cleared for top surgery, and his time on the
black-market hormones did not count toward this requirement. Reflecting on the hormone therapy Trig notes, “I made that choice. I can’t say that had that not been a barrier to receiving top surgery that I would have 100% gone for it.”

Trig’s surgery would be delayed longer due to his underemployment and lack of insurance that covered the procedure which he said was estimated by other transfolk to be between $8,000 and $10,000. Once Trig acquired a fulltime position with sufficient insurance to cover the procedure, he went in to get his top surgery. He has many tattoos and piercings. When discussing his top surgery with the surgeon, he expressed a desire to not have nipples. He had heard of complications and aesthetic issues from other transfolk and felt he would be better served by having a nice canvas for a future tattoo on his chest. Trig’s surgeon said that he would not do a double mastectomy and liposuction for gender-affirming top surgery without the nipples. Trig acquiesced and his surgery was mostly covered by insurance. Trig received a bill for a portion of the procedure which was not covered by insurance and the bill came to $2,800. Relaying this Trig stated, “All that is to say, the $2,000 of that $2,800 that I had to pay was for those damn nipples.” He feels the nipples came out well and that he is pleased with the aesthetic, but still feels that if he had his druthers, he would not have gotten them.

Trig is waiting to see if he will need any revisions or additional liposuction.
Trig’s story highlights some of the ways in which the biomedical schedule and expectations do not match the desired treatments and bodily changes needed by the transgender patient. This chapter will explore how the biomedical schedule influences gender-affirming care practices and the views and experiences of transgender patients.

Biomedicine tends to structure the provision of gender-affirming care starting from procedures that are more easily reversed to those that are more difficult or currently impossible to reverse. This advancement of procedures is shown in the chart below and will serve as the ordering structure of the presentation of the findings to follow.

**Figure 1: Gender-affirming care Process**

In presenting the research findings, participants in the study will be identified with their self-defined gender identity. While this may present some challenge in determining exactly who someone is based on the biomedical and binary definitions of identity, it is essential to the heart of this study to honor these chosen identity categories.

Most medical literature maintains the sex-assigned-at-birth as the means for classifying one’s gender-affirming care goals and to describe the procedures. This practice is often supported by a desire to maintain ideas of specificity within the practice of medicine. In an opinion piece by Amine Sahmoud, Daniel Hamilton, and Rachel Pope in *Obstetrics and Gynecology*, the authors challenge this stance and suggest instead an approach that uses gender-inclusive language reducing the risk of triggering patient dysphoria without
losing the desired medical specificity (Sahmoud et al. 2022). Therefore, in this paper, descriptors are based on patient’s identities and gender goals so as not to continue to ground the research in descriptors that feed into bioessentialism of gender or assert authority over the participants’ own experiences of self and gender. Pronouns of participants, when used, are based on the pronouns used by the given participant and may or may not appear congruent with their gender identity. Terms are defined in the glossary.

The Biomedical Schedule

The general schedule for transgender individuals seeking biomedical gender-affirming care follows a predetermined series of medical interactions starting usually with mental health where a provider will make a diagnosis of gender dysphoria and will assess an individual’s need for hormone therapy or surgical intervention(s). The mental health provider will then proffer a letter certifying this diagnosis. All of the participants in this study underwent care prior to the release of the WPATH Standards of Care Version 8; thus, all would have had to secure a second letter from another provider confirming the diagnosis, with the exception of those providers who used informed consent models. After receiving the letters, a patient would then be eligible to begin hormone therapy and would be prescribed some combination of hormones and hormone blockers. After a period of time on hormones the patient would then be eligible for consideration as a surgical candidate. Not all individuals will be cleared for surgery as factors such as body mass index, medical complications, or financial constraints may lead to additional barriers for some patients. The order and type of surgeries is heavily determined by the patient’s desired outcomes and the availability of procedures within their geographical region or health network. Some procedures, like gonadectomies, may
require hormone replacement for health reasons. Not all transgender individuals will engage in all aspects of gender-affirming care, and full “sex reassignment” is not always the desired outcome. This timeline is also not necessarily congruent with how transgender individuals wish to engage in their gender-affirming care, though some may feel pressured into following this course of action. Some (n=3) participants addressed these concerns directly with statements like,

[transgender individual]: I wasn’t in therapy at the time so it was important for me to be able to pursue this [hormone therapy] without that [therapy].

[transmasc demiboy]: It’s interesting because, I keep saying, I mean I’m very happy with my results on testosterone, and I’m happy I made that choice. I can’t say that had that not been a barrier to receiving top surgery that I would have a 100% gone for it.

or questioning the need for aspects of care, especially the surgical components.

Additionally, one third (n=7) of the participants expressed desires for more autonomy to choose the procedures that would make-up their gender-affirming care process, rather than following the biomedical model as laid out.

DBH: If a provider were to ask you for input on the bettering how they can offer gender-affirming care, what would you like them to know?
[transwoman]: To listen to their patient more than to tell them what to do, to respect the same thing but. While there are definitive, definitive procedures and treatments that not everyone will need them. And to make sure to understand better what their patient does need, and to be or subject to that.

[transman]: There can be a really all or nothing perspective when people are looking at starting like Oh, well, if I start, then all of this stuff is going to happen, and I have to be okay with all of it, or none of it right and it's really much more of a spectrum, and also being you know it's like people can pick it. Choose what they want right.
I think there's a few parts and it gets really imperative that doctors not assume what types of transition their patients want to go through. So, and not to assume like that you're going to do things the certain order, or what kind of care people want.
[transgender individual]: She does great work she's not like a lot of other providers in that she doesn't require you to buy a whole bunch of treatments up front. It's all a la cart.

None of the participants of this study expressed a requirement for transgender individuals to engage with the biomedical system to be valid as a transgender individual.

There has been an undercurrent of this sentiment within some portions of the transgender community. This view is referred to as transmedicalism and necessitates one to receive a diagnosis of gender dysphoria and seek biomedical interventions in order to be considered as transgender. These viewpoints were only mentioned by one participant stating,

[transgender individual]: not every transperson feels like they need hormones, and it can be quite transmedicalist to suggest that transpeople need to be on hormones to be valid.

and may be a reflection of the current broad common definition of transgender in the U.S. and a shifting of identity away from a dysphoria focus to one of inner sense of self.

While biomedicine has a view of gender-affirming care as an advancement from one end of a spectrum of man and woman to the other, the transgender community often views it as a selection of medical practices that should be options for gender affirmation based on patient desires around their gender identity, and not a standard model. As one participant put it,

[transman]: It’s simply treating anyone as if we’re a fingerprint. OK? We are all unique, and not one of us is like the other.
Chapter 5: Therapy

Demi identifies as transgender. She is White and in her thirties. She grew-up in a farm town that she describes as, “just grids of farms and cornfield, soybean oil, soybean fields as far as you can see.” While Demi lived in the largest town in her county access to the nearest freeway was about a 45-minute drive. Her high school was located about 30 miles from her home. During her mid-teen years, she connected with a community of transgender individuals through online forums and messages boards. She sought access to gender-affirming care when she turned 18 and came out as transgender to her family.

She describes her father as somewhat supportive and helped her connect with a therapist advertised as specializing in gender and sexuality. On her first visit she was informed that the therapist had some transgender patients, but mostly worked with gay, lesbian, and bisexual clients. She began to see him. She felt that his experience may have been misrepresented because she would have hour-long sessions and pay $100 cash out-of-pocket. This was a huge expense as her employment at the time was minimum wage and she did not have insurance. The therapist was located 50 miles from her home and was the closest specialist to her. Additionally, she was now attending college classes 50 miles in the opposite direction. She felt led on by the therapy sessions and never felt that he addressed her concerns around gender, rather focusing on her family connections and general affect.

After spending over $1,000 on sessions, she realized she was not getting closer to getting a letter confirming her diagnosis to access gender-affirming
care. She received no referrals to physical care providers from the therapist. She noted that at the time, “you really had to kick care providers in the ass to get them to care and provide care.” Demi wouldn’t start hormone therapy or connect with a therapist to provide the gender-affirming care she desired until she moved to a larger metropolitan area.

Diagnosis by a mental health provider is the current suggested entry point for individuals seeking gender-affirming care and is required by many healthcare systems and insurance companies. The therapist letter(s) is required by these providers and insurance companies in order to initiate or cover physical medicine interventions focused on gender-affirming care.

**WPATH Standards of Care**

The history of the development of the WPATH Standards of Care has been discussed earlier in this dissertation. Overall, there was not much disagreement with the WPATH Standards of Care as a whole, with a strong exception regarding the mental health letter requirement. As one participant commented on the WPATH,

[transgender individual]: I think they’re [WPATH] trying very hard to do the right thing…overall, I mean in terms of what they talk about with mental health and everything else. I think they’re, overall, a force for good.

Excluding the letter requirement, which over half of the participants (n=13) stated disagreement with, the only other critique mentioned by participants was around the lack of inclusion of non-binary transgender identities; however, this has been expanded in the WPATH Standards of Care Version 8 which was released around the same time as the termination of this study. The largest issue that transgender individuals have with the
Standards of Care is the requirement for therapist letters in order to access physical medical care; this requirement was not removed from the Version 8 revisions but was reduced to a recommendation of only a single letter. For many, this requirement is seen as a form of biomedical gatekeeping and, as will be discussed later, based on antiquated and incorrect diagnostic criteria. Only one participant agreed with the need for the letters stating,

[transwoman]: I still think there should be some form of vetting process to stop buyer’s remorse. Because a lot of this, there is no going back. There’s no returns.

Other participants while disagreeing with the requirement attempted to explain or logically justify a medical reason for the letter requirement, though this was more focused on legal or bureaucratic aspects of care,

[female transgender individual]: he [endocrinologist] wants that double layer of protection from lawsuits, I’m sure. But, you know, it’s about folk trying to, about having a second opinion about whether or not your gonna give them [hormones].

[transguy]: And then I start with a new doctor and then they want to see everything. And I’m like, oh yeah, you need, you need some proof before you treat, you know.

The disagreement with the letters requirement appears to stem from a sense of medical gatekeeping reflected in the following examples of quotes from participants.

[transgender individual]: BMI is stupid, WPATH is stupid. Both of these things serve as gatekeepers, and we don’t need more gatekeeping.

[transguy]: I don’t think that therapy should be a gatekeeper. I don’t think any therapist should get to say yay or nay. You are who you say you are, and you get to access services or not.
[transgender individual]: Others would insist letters are required even after five plus years of HRT [hormone replacement therapy] just to switch from one endocrinologist to another even if I as a patient just moved.

This sense of gatekeeping is engrained throughout gender-affirming care, and has been a key feature of care since procedures began. One historical example of this, which was recently critiqued by transgender activists (Joynt 2022), was the gatekeeping by Harold Garfinkel and his portrayal of his patient Agnes as an individual who engaged in deceit in order to access surgery (Garfinkel 1967). Additionally, a general sense of political, religious, and social gatekeeping continues to date, this will be explored in chapter ten.

The other aspect of the gatekeeping is an overreliance on the DSM as the tool for making the mental health diagnosis in the U.S. The WPATH, as an international body, endorses the use of local diagnostic tools. Transgender patients have had to navigate these tools and professional hurdles since the start of biomedical interventions, and continue to seek and find willing providers and share information with other transgender individuals to move through the systems more easily. One participant was able to access a supportive and willing provider and noted,

[transgender individual]: for as long as we have to still abide by WPATH I can point other trans people to the places that I went and it took me a month.

A strong illustration of this information sharing was relayed by a participant who had to assist another transgender person with a non-willing therapist.

[transmasc demiboy]: I was like, you need to like, you know, GTFO [get the fuck out] from the [hospital] and go to [other hospital], and like, you know, and they were like, well I don’t know. Because, like, they were kind of anxious and like, they were like, well I hardly start talking to someone so I don’t. I’m like no, like you can pull out whenever you want. Like, you don’t have to stay and they tried to stick it out for a couple of months with this, and there were just like hoop after hoop. It was like they started seeing the therapist and the therapist was like, I
don’t know if you’re like, if you really qualify because, you know, you’re, you know, you’re saying you’re like non-binary, but that doesn’t mean that like, this that, and the other thing, like you don’t want any surgery so you can’t [start hormones]. It was like totally, the, all the worst, like, the worst things. And I was like, I will drive you to [other hospital] myself. And like, they eventually got out of that, went to [hospital], two weeks later had their testosterone.

The dragging on of sessions, or reluctance to grant a diagnosis was mentioned by one sixth (n=4) of the participants, three of whom after changing providers were granted letters and a diagnosis quickly. Some examples of these challenges are as follows.

[transman]: I had a few therapy sessions that, that were a little uncomfortable [laughs] but I think that was more so because you know, you gotta, it’s kind of like shopping for a therapist. So, once I found the right therapist then it was a lot better.

[transgender individual]: And like ten sessions later. What about this? Scribble scribble, so then you’re out a grand [$1,000] and you’re not even getting into anything like letters, transitioning, or anything else; and me being then the now young adult, and then experiencing this process I was kind of expecting the expert to be able to guide me better. Work with me better.

[transgender man]: She was the last person that needed to sign off on me like getting a letter for testosterone because I was under 18…I just remember she ditched two of my appointments, and then the one, I was only suppose to have one appointment with her, and I went on my own because I had a car and could drive…She told me to my face, I don’t believe any parent could be that supportive of their transgender child. I’m gonna need them both to come in here and like prove it.

These narratives within the community further erode the sense that mental health providers should have the authority to be designated as a required step to access care and emphasize the sense that the role is more about gatekeeping or a way to increase revenue rather than a patient-centered approach to enter into gender-affirming care.

Informed Consent
In contrast to reliance on therapists’ letters, and while not explicitly endorsed in the WPATH Standards of Care Version 8, informed consent has been a model practiced by some medical systems and providers of gender-affirming care regarding the initiation and continuation of hormone therapies. Informed consent models provide the information to patients on the risks and potential benefits of hormone therapy or other interventions and then allow the patient to make a choice around their care. This process is performed by the physical health provider and bypasses the role of the therapist. This reduces the number of steps to access hormones or other procedures and gives the transgender patient more autonomy over their healthcare choices.

[transgender individual]: I was able to get on hormones through a doctor with [community health center] because of the informed consent that they now have, where you don’t need all the gatekeeping as much. You just need to sign some papers and things and so we stared like medically, because before then I’d been buying a herb called Pueraria.

One third (n=8) of the participants in this study reported accessing their care via informed consent. Transgender individuals prefer the informed consent model as a means of removing the role of the therapist letters which is often framed as one of gatekeeping.

This model does not have as much use among surgeons, aside from private providers of cosmetic procedures, due to the requirements of the diagnostic letters by insurance providers to approve coverage. For transgender individuals who have access to multiple medical options, or who are able to travel, informed consent is a preferred model,

[transmasc demiboy]: I specifically went there because I did not want to have to jump through a bunch of hoops to get my hormones.
Resources and information on providers who use informed consent models are shared among transgender individuals in order to bypass perceived medical gatekeepers.

[transgender individual]: There is a site that lists all the clinics and all the medical facilities in the U.S. that offer gender-affirming care under the informed consent model, where you don’t have to have a therapist letter, you don’t have to have a psychiatric note or anything. You can just go to your doctor and say, I’m transgender, I’d like to start hormones.

Somewhat like informed consent is the presence of mental health providers who are willing to provide letters, without a patient needing to see them over multiple sessions or prove that they meet the diagnostic criteria.

[transguy]: She [therapist] was very anti-gatekeeping. She was like, I will write you a letter, just let me know when you’re ready…like I’ll do it right now, first session, whatever, you know, you know it’s your life and that’ll be fine.

[transgender individual]: I got a referral to somebody who will probably write you a letter in one or two sessions depending on how long it's been for you.

Providers like these are maintaining the medical schedule, however are operating on a less explicit informed consent model. The endocrinologists and surgeons who receive these letters from the patients’ therapists would not know the difference.

The Diagnosis

In Read My Lips: Sexual Subversion and the End of Gender, R. A. Wilchins (1997) states, “It is not so much that there have always been transgendered people; it is that there have always been cultures which impose regimes of gender (1997 p. 67).” Within Western society, the role of classifying and categorizing diseases and disorders is an essential part of the practice of biomedicine. These classification systems dictate
everything from coordinated care plans, insurance coverage, and treatment options for professionals and patients.

The requirement for letters from a mental health provider by the WPATH Standards of Care and the diagnostic criteria defined in the DSM are deeply intertwined and rely on each other. Much the way separating gender identity and sexual orientation presents complications, the letter requirement and diagnostic criteria are deeply enmeshed in the U.S. medical culture. It is challenging to determine if the disagreement with the letter requirements is only about medical gatekeeping or is influenced by distrust and disagreement with the historical and current diagnostic criteria. Over half of the participants in the study directly mentioned disagreement with the therapist letter requirement; however, a similar number, when prompted about an ideal process for gender affirmation, mentioned a desire for affirming mental health services as part of the delivery of gender-affirming care.

The first step of the biomedical model is to receive a diagnosis of gender dysphoria (formerly known as gender identity disorder). Since gender identity disorder was added to the DSM, there have been questions and critiques from the transgender community. Early community perception among LGBTQ individuals was that gender identity disorder was a way to continue pathologizing homosexuality. Due to the timing of the removal of homosexuality and the addition of gender identity disorder occurring at that same time. Additionally, The DSM-III and the DSM-III-R both drew a distinction between GID in boys and girls: for a girl to be diagnosed, there had to be a ‘stated desire to be a boy,’ but for a boy to be diagnosed, there had to be an ‘intense desire to be a girl’ (Burke 1996 p. 62).
These distinctions between diagnoses for “boys and girls” raised questions in feminist, gay rights, and other social and political groups. There was no explanation given for why the differences in diagnostic criteria exist between the sexes. The DSM-IV shifted from diagnosis based on desires or stated behaviors to behavior indicators (Beek et al. 2016) and presented uniform language for diagnosing those assigned-male-at-birth and those assigned-female-at-birth. The transgender community responded to these changes with mixed results, as many were hoping for a reclassification entirely.

Transgender activist, Joanne Herman, declares in her book, “Transgender Explained for Those Who Are Not” (2009) that:

As a transsexual woman, I have a mental disorder, or so says the current *Diagnostic and Statistics Manual of Mental Disorders, Fourth Edition (DSM-IV)* of the American Psychiatric Association. My diagnosis code is 302.85 – Gender Identity Disorder of Adolescence of [sic] Adulthood (GID). Gay men and lesbians used to have a mental disorder too. That was true until homosexuality was removed from the *DSM* in 1973. Why am I still in the big book of mental disorders so many years later? (23)

This sentiment is shared by a number of transgender and social justice activists. Arlene Istar Lev in “Disordering Gender Identity: Gender Identity Disorder in the *DSM-IV-TR*” (2005) states that:

The inclusion of Gender Identity Disorder within the official diagnostic nosology of mental disorders is a controversial topic that invokes many questions about the role of the psychiatric establishment in the labeling of those which violate societal norms, particularly norms involving sex and gender issues (2005, 36).

Activist groups often find the discussion of diagnoses related to being transgender to be difficult, as a diagnosis is often critical for individuals seeking to adjust their bodies through gender-affirming treatments like hormones or surgical interventions. This divide between individual autonomy and medical authority can create complex social interplays.
With the publication of the DSM-V (2013), the American Psychiatric Association made a strong statement in relation to gender identity by acknowledging that everyone has a gender identity and having one that is unexpected is not a sole indicator of a disorder (Valentine 2007). Gender identity disorder would be renamed in the DSM-V to gender dysphoria, a seemingly less stigmatizing label and indicating an incongruence between the experienced and assigned gender (Beek et al 2016). The overarching category was also separated into its own subcategory of gender dysphoria separating it from the sexual disorders connection (Beek et al 2016). In the previously mentioned editions of the DSM, gender role was considered to be male and female and followed the social and cultural binary. In the DSM-V, gender roles, as a concept, are considered multi-category concepts on a spectrum (Beek et al 2016). Sexual orientation specifiers were also removed from the category as it was deemed no longer necessary and many professionals were unsure if the base line for determining sexual orientation should be based on gender identity of the patient or biological sex at birth (Beek et al 2016).

These community member views are important as the transgender community shares medical knowledge on the lay level and tend to be critical of gatekeeping practices or understandings interpreted as not being informed by transgender individuals but rather cisgender providers. The push to remove the diagnosis has not lessened, but as will be explored in the comments, some transgender individuals conceptualize their concerns as part of physical medicine rather than mental health and thus feel it should be diagnosed and treated as though the sex characteristics were a physical defect. As one participant stated,

[transgender individual] I personally, how I describe transgender care is the same way you would treat any other birth defect or cancer treatment. Because these are
cellular structures that are mutating in undesirable ways. And its largely a biproduct of what is effectively a birth defect or a birth medical complication where somebody didn’t go through puberty the way that they should have for a multitude of reasons.

My study also revealed that while there have been updates to the diagnostic criteria, some mental health providers may still be led by previously included indicators when questioning or counseling their transgender patients, such as the interaction described by the following patient:

DBH: Are there any parts of your gender-affirming care process that you feel triggered dysphoria for you?
[transwoman]: Yeah, the intake, they always ask these dumb ass questions about whether or not you tuck and whether or not you sit to pee. And I always answering, but I always feel like I’m being judged, like, what the Hell does this have to do with whether or not I’m experiencing dysphoria and want to change that, like, you know, like, I go to my intake at [hospital] in the mental health, health professional that does their intake for their trans programs, straight up just asked, what do you wear? Panties? Like, I don’t. What the fuck’s that got to do with the price of rice in China? Like why are you asking me this? I’m, I’m here because I’m trans. Like we’ve already established that, if I wasn’t trans, I wouldn’t be here. Why are you asking me questions about my, my bathroom habits and my bedroom habit, and what I wear? It’s just ridiculous and it really is like dysphoria inducing and just cringe as Hell.

The general sense from the interviews was that mental health professionals do not actually understand transgender individuals and use a checklist to diagnose or that the tools do not adequately represent the lived experiences of transgender individuals resulting in the need to construct appropriate narratives to meet criteria and access care. Much of this is reflected in one participant’s structured journal entry which read:

[transgender individual]: Another, [provider], couldn’t form a professional opinion/determination without the aid of a robot that reads ‘Scantrons’ (bubble forms) and subliminally expects patients to put on what I describe as a monkey suit in order to dance in whatever manner that won her favor.
Other participants expressed feelings that they may not meet the criteria for providers, due to shared community knowledge around the criteria. Fear of slipping up or not qualifying as transgender enough to receive care are strong.

[transmasc demiboy]: I think the easiest way to put it is, I want to live, because for a time I can’t say that was always true. Especially in the wake of like, especially in moments where I felt like really hopeless about being able to transition, or like, it there was, if I would even, like be qualified, air quotes, as being trans because it seemed, for so long that, like it was only regulated to like a small section of the community. It's like it felt like I had to prove my transness to these people, who were like almost blocking, like gatekeeping the care I needed and I knew I needed in order to, you know, whatever, to experience my transition, to live my truth…I felt like even identifying as non-binary at the time that that enough was a flag that could have prevented me from receiving care, because so much of the conversation at that time it felt like was very binary, and, and it still is in many ways very binary.

Constructing narratives to meet provider expectations is an important aspect of transgender care. Several participants noted the need to alter or meet specific narrative elements as part of their process to access gender-affirming care. I have included several quotes from participants that illustrate this sentiment here.

[transguy]: You know, you gotta play the game. But it definitely feels like jumping through the hoops and playing the game.

[transguy]: Some doctors ask, are really just kind of weird and off the wall. I’m like, I don’t know why you need to know that, you know, the first doctor I saw for HRT where I was like Nope. Nope I’m out of there, was, you know, just it definitely seemed like she wanted to hear a specific kind of narrative, and it was like, I don’t really know that I fit into that narrative, but I think I know what to say to get us where I want to go. Which can be, you know, that, that leaves you feeling weird, and it’s like, Oh I have to kind of, you know, tailor, tailor my presentation to this doctor’s, so I can access care.

DBH: And what things or factors went into your decision to access hormones? Did you do your own research, or did you just rely on doctors, or-? [female transgender individual]: No, I did my own research. Matter of fact I BS-ed half of the story just to make it easier. I knew what they were looking for.
DBH: Oh, well I'm not actually looking for anything specific, but
[female transgender individual]: I knew what they were looking for
DBH: OK, got ya.
[female transgender individual]: Right, I knew what to, to say to, you know, get
what I wanted.
DBH: Yeah.

This last interaction was interesting, because I had noted earlier in her interview
following a telling of her early childhood that the narrative felt formulaic. She did not
shift into a more personal and less of a biomedical transgender formula-driven narrative
until about halfway through the interview. It was a nice connection to make and create
space to learn more about her journey with gender.

This sense from participants that the diagnosis by a mental health care provider
was unnecessary (expressed by over half of the participants, n=13) and that the diagnostic
criteria used by their providers were inadequate (expressed by just under half of the
participants, n=11) is heavily influenced by the sharing of information among transgender
individuals regarding the challenges and barriers to accessing gender-affirming care, as
will be explored in chapter eleven. It may be further complicated by the social stigma that
is attached to mental health diagnoses in the U.S. A majority of transgender individuals
would prefer an informed consent model that does not require a mental health diagnosis
from, or authorization by, a therapist in order to access gender-affirming physical
medicine procedures.

Despite the sentiments that mental health providers may use antiquated or flawed
diagnostic tools and that they should not serve as a gatekeeping step to access care, a
majority (n=13) of the participants also expressed a desire for competent mental health
providers to be part of the gender-affirming care process. This was often suggested as a
supportive professional for navigating social changes that may occur with transition and also being a supportive figure to overall well-being. Participants were clear in expressing this desire for therapy and counseling support,

[transgender woman]: I would recommend them to get into counseling if they’re not already.

[transgender individual]: I think counseling is very important for, because, especially if you’re a young person. I don’t want to say should, but in my opinion a therapist would be a great place to go.

[transman]: THERAPY HAS BECOME VITAL TO ME OVER THE YEAR [written in all caps on journal entry].

This is a very different role from analysis, diagnosis, and gatekeeping. Finding a provider to receive this support can be a challenge for transgender patients for two reasons. The first is a need to find providers who are competent at working with and understanding the true needs and experiences of transgender patients. The second is finding providers who meet that first criterion and are also covered by the patient’s insurance if they are unable to pay out of pocket for those services.

A couple (n=3) participants expressed financial challenges to accessing ongoing mental health services, or finding supportive providers:

[queer transgender individual]: I definitely needed therapy, but I couldn’t find one that worked, there’s not enough LGBT friendly, like, therapists and stuff out there.

DBH: And just because, I’m going to ask because you said that. Do you have a therapist or counselor too? [gay tranny]: I wish I could afford one.

Only one participant described counseling or mental health services as not being as helpful as they would like but also was a supporter of this being part of the process. That participant noted that,
transfemme demigirl: I don’t even really know how much therapy even, like it’s good for me because like my depression stems from external sources and, and like, you know, it’s like without fixing the external sources, it’s like, it doesn’t do much good, like, you know, other than like, you know, coping through it, but like, just, I don’t know.

This broader impact from external sources, such as political, societal, and familial pressures, will be noted later in chapter ten.

The DSM and WPATH Standards of Care, as well as individual provider and system choices to use informed consent models can be slow to adapt and change. Within the U.S., medical institutions hold the power to enact or deny gender-affirming care. While black market hormones, silicone injections, and other procedures may be enacted they are illegal, and state regulations on the practice of medicine confer this power exclusively to medical institutions. Institutions are large bodies of many individuals and often represent the views of the broader society in enacting regulations or practices. Mary Douglas in *How Institutions Think* notes that “individuals in crises do not make life and death decisions on their own. Who shall be saved and who shall die is settled by institutions (4).” This is especially evident within biomedical systems which are often tasked with determining who is eligible for specific care and who does not qualify.

Douglas notes that institutions confer identity to individuals, practices, and items through classifications stating, “It certainly seems circular to claim that similarity explains how things get classed together. It is naïve to treat the quality of sameness, which characterizes members of a class, as if it were a quality inherent in things or as a power of recognition inherent in the mind (58).” This practice of classification when identifying transgender individuals and classifying them as having a diagnosis of gender dysphoria creates tight barriers as to who has access or qualifies for care, where actual
experience may be much more fluid at the borders. These criteria are slow to change, as a rapidly changing set of practices and regulations would destabilize the institutional authority; however, the biomedical institutions have been flawed in the outweighed inclusion of cisgender interpretations and understandings of the transgender experience filtered through case studies and clinical notes. Due to social and political discrimination barring access to or creating undue barriers to medical training and biomedical employment for transgender individuals, these individuals are often barred from engaging in these formal discourses about their needs and experiences. This process for updating is self-validating when patients conform to the narratives expected or required to access care, leading to a false confirmation of the effectiveness of the current diagnostic tools or treatment protocols.

As with most regulations and guidelines the process for data collection, review, revisions, and eventual publication can take years. Empirical data that served as the basis for the recommendations and treatment protocols may be surpassed by the official adoption and publication and will not be reassessed until the next revision cycle, which may be years or even a decade in the future. In the meantime, patients and providers are left to navigate and adapt the tools within the constraints of large institutional guidelines, which may be quite divergent from the actual lived experiences and needs of transgender patients. This navigation will be explored in the next sections as it relates to the use of hormones and surgical interventions for gender-affirming care.
Chapter 6: Hormones

Heather is a White transgender individual in her forties. She started her medical transition informally due to a lack of insurance. She began her hormone therapy unregulated by taking the herbal supplement Pueraria mirifica. The supplement is believed to have an estrogenic effect. For Heather, the herbal supplement worked well, but she eventually sought to get her hormones through a doctor. This decision was sparked by a desire for additional effects and concerns regarding risks of altering hormones without medical oversight. The clinic she went to assisted her in applying for Medicaid and got her onto hormone therapy through an informed consent model. Heather was concerned that her doctor, who is known in the community to be adept at serving transgender patients, had not heard of the herbal supplement as she knew other transgender individuals using it. However, she was glad to start a more regulated treatment cycle that included monitoring of her hormone levels. Heather takes her hormones daily, placing a pill under her tongue and letting it dissolve. When I asked her about the parts of her gender-affirming care that made the most difference, she reported that the hormones had the largest impact explaining, “because growing breasts was like this amazing thing that, like, is the status for women.”

Hormone therapy has been a part of biomedical gender-affirming care since the practice began. The use of sex hormones to enhance desired or reduce unwanted secondary sex characteristics for transgender individuals is an important part of many transgender individuals’ gender journeys. All but one participant in the study were currently using hormone replacement therapies or had used them in the past (n=23). The
individual who was not using hormones made this decision due to their advanced age at
the time of initiating gender-affirming care (70s) and concerns about the risks
outweighing the potential benefits. The administration of hormone therapy did not pose
as many conflicts as the requirement for letters, aside from disagreements on dosages and
appropriate hormone levels and disagreements from non-binary transgender individuals.
Providers may find themselves being viewed as gatekeeping when reducing dosages or
holding off on treatments due to other health risks. For providers the administration of
hormone therapy for gender-affirming care may conflict with medical practices as “the
indication is not based on technical endocrine grounds, such as deficiency or excess of
hormone action (Gooren & Delemarre-van de Waal 2007, 73).” Despite this emphasis on
mental over physical indicators, a growing number of medical systems and
endocrinologists are enacting this care for transgender patients. Endocrinologists think in
indicators and contraindicators while making their decisions on care, risks, and benefits.
However, for patients these may be seen as facilitators and barriers, and they may not
agree with or interpret risks and contraindicators with the same severity as the
professional. While many endocrinologists operate following the WPATH Standards of
Care requiring a mental health letter, “it is the prescribing physician who retains
responsibility for the intervention and the quality of care (Gooren and Delemarre-van de
Waal 2007, 73).”

Hormone therapy is one of the more commonly accessed aspects of gender-
affirming care and is not as invasive of a procedure as surgery. Typically, transgender
individuals seeking to masculinize are prescribed testosterone, and transgender
individuals seeking to feminize are prescribed estrogen or progesterone. This was the
case for all but one participant using hormones and she had an additional prescription for low-dose testosterone due to levels registering too low when compared to cisgender women. Hormone therapy is not without risk and transgender patients mentioned either hearing about risks (n=7) or experiencing an unexpected health side effect (n=11) while engaging in treatment. It should also be noted that hormones are relatively easy to access on the black market. Only two participants expressed turning to this means of access before engaging with a biomedical provider to administer their hormones, though black-market use was not specifically solicited by the researcher.

Much of the known risks are derived from studies of hormone therapies used on cisgender individuals and are not related to gender transitions, or from case studies. Widespread and longitudinal studies on hormone therapy for transgender individuals are lacking in the literature. Some side effects of gender-affirming hormone therapies noted by Louis Gooren and Henriette A. Delemarre-van de Waal in *Hormone Treatment of Adult and Juvenile Transsexual Patients* (2007) are: venous thrombosis, atherosclerosis, pancreatitis, lactotroph adenoma, breast cancer, benign prostate hyperplasia, prostate cancer, and ovarian cancer.

Some of the risks associated with hormone therapy that were mentioned but not experienced by the participant mentioning the risk (n=1 unless otherwise noted) included: impact on blood pressure, potential reaction with psychiatric medications, weight gain (n=2), mood swings (n=2), stroke, blood clots (n=2), and male pattern baldness. The following quotes are examples of how these concerns were revealed.

DBH: And did you have any concerns before you started there, any safety or health concerns?
[Black transwoman]: Yes, the weight gain, what kind of changes it would bring about in the body with the hormone pills. That sort of thing. Mood swings.

[transmasc demiboy] I don't have the gene for like male pattern baldness and like, but my father like had you know, male pattern baldness like I didn't know if that was gonna be a thing.

[transgender individual] So because if you take like 8 milligrams, or something, that's where you can get the blood clots and stuff because your body tends to react to the higher amount of the one hormone builds up the other.

Side effects that were attributed to hormone therapy by participants (n=1 unless otherwise indicated) included: cramps, blood clot, frequent urination, fatigue, nipple/developing tissue pain (n=2), heart issues, increased cholesterol, brain fog, too low levels of testosterone, increase in cortisol, and weakened skin. The following quotes are examples of some of these experiences by the participants.

[transman] I got a blood clot. It was a, it was a major health issue, because they, my doctors, ended up wanting to stop my testosterone therapy because of that blood clot. So that was some knowledge I gained, as well as some sadness. But it wasn't proven that that was the cause so I was able to get back on the testosterone.

[transgender individual] And so I just opted for an orchiectomy at the time. And, and that got rid of the need to take spironolactone, which hugely, and it causes elevated cortisol level which is not good, especially for a transperson.

Despite these side effects, 19 of the participants expressed that hormone therapy improved their overall health referencing impacts on both physical and mental health. Of the 11 participants who mentioned experiencing side effects, nine directly stated that hormones had improved their overall health. No participants expressed that hormone therapy resulted in a worsening of their physical or mental health. Hormones appeared to hold similar meanings in relation to affirming one’s gender identity regardless of whether
the hormone was testosterone or estrogen, for that reason I will not be separating these out unless there was a unique indicator. Improvement in health was indicated in quotes such as the following:

DBH: And what parts of the gender-affirming care process would you say reduced your dysphoria the most?

[transgender individual] The hormones because, I want to say the hormones first, because growing breasts was like this amazing thing that, like is the status for women. And like it was a thing that when it happened it was like Wow! I can't believe this.

[transgender individual] after I got on hormones. It just kind of. Everything fell into place. I figured out the name I wanted. I socially transitioned, and I just kind of like tried to settle into. I, I called it like the flow.

[transgender individual] And so, since starting hormones, I think mentally, things have continued to lighten up my feelings and capacity for emotion has deepened in surprising ways, and I think just that whole process of allowing myself to feel more, allowing myself to be okay with sort of my own shortcomings and imperfections. You know all that breeds the self-love and self-compassion that, like I said it frees it, it frees me up, and I think it frees me up in a way that I’m now sort of discovering.

Hormones are not a miracle that will “cure” gender dysphoria and it is advised that “the limitations of cross-sex hormone administration in adult, and certainly elderly, transsexuals, should be frankly discussed (Gooren and Delemarre-van de Waal 2007, 74).” For a quarter of the participants in this study (n=6) they felt that the hormone therapy, while beneficial, fell short in providing the changes that were expected, stating things like,

[transgender individual] sometimes I wish hormones did more than they do, but I’m glad they do what they do.

[transgender individual] I’m frustrated that I don’t have enough fatty tissue in the butt and breasts area.
The positive reception of hormone therapy by transgender patients may also contribute to concerns about dosages and an emphasis by some patients that more is better when it comes to hormone therapy. This view was expressed by a quarter of participants (n=6) in the study and was reflected in statements like,

[female transgender individual] even though I had already been on them for six months, yeah six months, I got a nudge which is exactly what I asked him to do, which he did.

[transgender individual] I don’t want to be taking less of it just because, I don’t know, because it’s estrogen, like, I want it.

There was no overlap between those participants expressing the more is better view and those who wished that the hormones had a stronger impact on their gender presentation.

Hormone blockers for adults are primarily used by individuals assigned-male-at-birth who seek feminizing treatments. The most common blockers mentioned within the study are spironolactone and finasteride. Among the participants who were assigned-male-at-birth and were engaged in hormone therapy (n=15), six referenced feelings related to taking these testosterone blockers. Three expressed positive views of blockers, two expressed negative feelings, and one said they had mixed feelings. In a unique case one of the transmasculine individuals who was assigned-female-at-birth was prescribed finasteride to address hair loss concerns and had mixed feelings about needing this prescription. The following exchange with a participant, the researcher, and an unseen family member shows one of the positive views regarding the use of hormone blockers, in this case, spironolactone.
[transgender woman] So on the medical side I went to a doctor, and she allowed me to take. What is this T [testosterone] blocker?

[Other voice off camera] Spiro

[transgender woman] what?

[Other voice] Spironolactone.

[transgender woman] Spiro- Agnew? I don’t know

[DBH] I know what you’re talking about. It’s fine.

[transgender woman] was the T blocker, and I, I was so glad. That T is poison to me. I believe that it’s poison! And I know, medically, it’s not.

Hormones are an important aspect of gender-affirming care for transgender individuals and, for some, are the only physical care intervention that they will enact. Despite potential risks or side effects transgender patients measure the benefits to their health from hormone therapy as positive.

It is difficult to measure a sense of gender in relation to hormones as society uses a great deal of culturally gendered notions to describe sex hormones. The placebo effect could be a factor in perceptions of hormone use. Participants in the study mentioned mood, emotions, aggression, confidence, and other gendered indicators as results of hormone therapy. Being able to disentangle these experiences from the actual impacts of hormones, or reactions due to social expectations of having these hormones, is a challenge. There were four participants whose descriptions of the hormones were clearly influenced by social ideas of gender, three describing feelings of experiencing pregnancy,


and one claiming to be experiencing symptoms of menopause. In The Egg and The Sperm, by Emily Martin (1991), health or scientific language at the cellular or chemical
level was shown to be subject to influences of the broader social views on gender. Martin explores the ways in which scientific and medical descriptions of egg and sperm cells are reflective of gender expectations associated with the sex markers of these cells rather than unbiased observations and conclusions. Descriptions of hormones may be influenced in this same way, and exploring this would be worth more research.
Chapter 7: Top Surgery

Ste‌ph is a White transgender individual who is in her fifties. She kept a journal of her visit with her surgical team following a breast augmentation. She entered the clinical space, which was a clean doctor’s office. A computer monitor in the room had a note stuck to it with the username and password written out, which she described as striking her as not being secure. The room felt small and she noted that there was Velcro on the door that would allow the staff to hang a backdrop for taking photographs of patients. She was nervous to be, “nude from the waist up during the examination.” She was also worried about the result of her surgery and whether her breasts would look normal or she would, “be told something had to be surgically corrected or was otherwise wrong.”

This visit was conducted by a cisgender woman staff member who reassured Steph that the surgery was a success and that she had achieved an, “extremely natural shape and had avoided the lack of movement/bounce that some patients end up with.” The staff member reassured her that the breasts were, “in a very good zone for [her] size and height.” Steph was nervous about having her breasts photographed, but knew that this was important for her surgeon to see the results, as the surgeon was traveling. Steph is now pleased with her breasts and says she is still, “integrating these surgical results into [her] body image.”
Top surgery can refer to both breast augmentation procedures achieving a more feminine presentation, and breast or chest reduction procedures achieving a more masculine presentation. The human chest is one of the most sexually dimorphic aspects of the human anatomy and the bust size and contour are usually visible to others even while concealed under clothing. Outside of clothing the chest is heavily regulated in the United States and the exposure of a woman’s breast, areola, and nipple is highly regulated by the State and society, whereas the man’s breast, areola, and nipple are free from censorship and regulation. For these reasons, top surgery is an important aspect of gender-affirming care for those seeking to have a masculine or feminine presentation and to engage in masculine or feminine modes of comportment. Top surgery may also be accessed by non-binary or genderqueer individuals and may involve changes toward either direction of the sex binary depending on patient needs and outcomes desired.

Gender-affirming care surgical procedures for both breast augmentation and reductions are heavily guided by research done on cisgender individuals. When it comes to chest reductions, “a large body of literature concerning the optimal technique for performing SCM [subcutaneous mastectomy] exists, but most of it focuses on women with breast disease or men with gynecomastia (Monstrey et al. 2007, 137).” Procedures for breast augmentation are referenced as being similar to that for ciswomen with statements in the literature like, “principles of augmentation mammaplasty are similar to that of natal females (Schecter 2017, 32),” or, “the implantation of mammary protheses is not essentially different from breast augmentation in a biological female patient (Monstrey et al. 2007, 117).” There is a lack of medical studies focused on these procedures enacted for gender-affirming care. The literature that does exist situates
descriptions of transgender patients within a binary framework of gender using terms such as male-to-female, female-to-male, transwoman, and transman. These descriptions fall short by not including non-binary transgender identities within the medical framework.

When it comes to breast augmentation, the procedures are often described as enhancing inadequate results produced by feminizing hormone therapy (Monstrey et al. 2007). The medical literature describing the procedures specifically for transgender individuals notes that those assigned-male-at-birth tend to have a wider chest, smaller areola, and more developed pectoral muscles as considerations that a surgeon should take note of. The primary procedure performed is the subpectoral pocket positioning for implants, despite the risk of displacement due to muscle activity in this region (Schecter 2017). With the relative similarity in techniques and procedures for transgender and cisgender individuals there is less discussion of these procedures specific to transgender patients. Differences noted are that transgender patients tend to choose larger implants than cisgender women and a possible need to detach muscle tissue from either the sternum or thoracic cage to adjust the inframammary crease (Monstrey et al. 2007, Schecter 2017).

There is a wider range of procedures performed to reduce and contour the chest to achieve a more masculine appearance. In order to determine the best methods, a surgeon will assess a variety of indicators such as “breast volume, degree of excess skin, nipple-areola complex size and position, and skin elasticity (Monstrey et al. 2007, 138),” as well as considering their own skills and experience with these procedures. Many of these elements are impacted by genetics; however, some can be impacted by cultural practices.
Loren Schechter notes that, “breast binding…may lead to the loss of skin elasticity (2017, 61).” The literature’s emphasis on these indicators notes that with increased chest ptosis and with decreased skin elasticity, the complexity of the procedures performed and the potential need for revisions increased (Monstrey et al. 2007, Schechter 2017). Monstrey, Ceulemans, and Hoebeke note that as a result of the wide range of options, levels of skills, and experiences among surgeons, “the FTM transsexual patients are rightfully becoming a patient population that is better informed and more demanding (2007, 149).”

Top surgery was a topic brought up by 83% (n=20) of the participants in the study. Of these, ten had undergone top surgery (breast augmentation n=3, chest masculinization n=7) as part of their gender-affirming care and nine were wanting or considering engaging with this care (breast augmentation n=8, chest masculinization n=1). Only one participant expressed that they were not intending to have top surgery noting that

[transgender individual] I don’t intend to do any facial feminization or breast augmentation. All the hormones work, so I’m happy.

Among those wanting or considering top surgery, six participants cited cost as the primary factor preventing them from receiving this care (chest masculinization n=1, breast augmentation n=5).

[trans person] I do want top surgery but financially it’s just not affordable right now.

[gay tranny] The, on the major goal of getting it [breast augmentation], but I don’t know. I’ve been looking at it, but the, the money of it is very expensive.
DBH: OK, and what, what would getting the facial feminization and breast augmentation mean for you?
[transgender female] It would mean a great step, like, I would feel like that’s the peak of everything in my life. Like I really understood myself and transformed fully, like the full transition.
DBH: And that, are some of the, are there any barrier for accessing that care for you?
[transgender female] Cash, like it’s expensive to do. That is the greatest barrier.
DBH: Does your insurance cover either of those procedures?
[transgender female] No, they view it as cosmetic something, so they don’t.
DBH: OK, and then to pay for that, are you just, you know, saving-up money? Are you doing fundraising? How are you hoping to gain that cash?
[transgender female] Saving, I’m saving and again, I’m hoping to find a person who is well off, really have a great job and support me, and maybe help pay for it.

There were no concerns from individuals around health complications in making their decisions to have top surgery, nor was this raised as a reason for delaying care.

Reasons for entering into this care level were related to decreasing dysphoria. The reduction of dysphoria was directly mentioned by five participants. There were almost no regrets in relation to accessing top surgery procedures with the exception of one participant who received her procedures via the black market and reflected,

[transwoman] I got them way too big. I think I went too far.

Overall, the impact of top surgery as a good thing was captured in quotes from participants like the following,

[transguy] I was very chesty, and it was you know, was one of the biggest areas of dysphoria for me, so I had chest surgery, top surgery. … So, after top surgery, that was, that was a, you know, huge change in terms of, you know, mental health and just the daily dysphoria.

[transgender individual] Lots of women seek breast augmentations for lots of reasons, maybe they just didn’t develop the way they want. Maybe they’re cancer survivors. What have you. And I don’t know their state of mind when they do so, but it just, things like that play such a huge role in my mental image of myself and my, my mental map of my body.
DBH: And do you feel that any specific part of your gender-affirming care process reduced your dysphoria the most?
[transguy] Top Surgery, I think probably had the biggest effect just because it’s the most immediate, the effects of T [testosterone] are slower.

In regard to top surgeries, there were only three participants who mentioned any side effects and those were pain, revisions, and dog-earing (an excess of skin or tissue at the surgical incision site).

[transgender individual] I was not prepared for the amount of post-surgical pain that there was going to be. I don’t even know if the team, the surgical team was completely clear about just how much it was going to hurt afterwards.

[transguy] having to do the revision, like, you know, that was unfortunate. I think that it was really the surgeon was maybe not as familiar with, you know, doing that procedure on people who hadn’t had HRT yet.

[transmasc demiboy] I have like very small, like, fatty pockets, like not quite a dog ear, maybe like a puppy ear. I dropped here [indicates location on the body]. So that’s why I don’t know if I’ll go back and get revisions or not.

While insurance companies and some medical systems have tended to define top surgeries as cosmetic, the aesthetic component of these surgeries was only mentioned by two participants and this was in relation to “natural” appearance for breast augmentation. Monstrey et al. notes in reference to breast augmentation that, “the patient should be informed that the complex feminine form and age-related changes of the breast cannot be imitated by using symmetric hemispherical prothesis (2007, 117).” This means that a natural effect may not always be as achievable. It should also be noted that natural and ideal might be used interchangeably here by some patients and providers when describing
the final result of these procedures. One patient described her post-surgical conversation
with her provider as such,

[transgender individual] She was like, oh you know everything, your skin looks
great. Your scars are healing fantastic. She said everything settled into a very nice
natural shape, unlike what you see with a lot of women, where you get that kind
of painting effect, where everything is like super symmetrical top and bottom.
Yours look very natural [like] they just formed, you know, naturally from
puberty. She was just really reinforcing that everything had come out as ideally as
she could have expected.

Overall, top surgery was seen by patients as a low risk and important element of
their gender-affirming care journeys and was primarily delayed or held-up due to
financial issues.
Chapter 8: Bottom Surgery

Ellen is a White transgender woman in her sixties. Sometimes she refers to her gender identity as just being a woman. As an older transgender woman who has complicating medical conditions, she was limited on the options for hormone therapy. She was initially placed on a T-blocker, known as spironolactone, and the hormone progesterone. Due to a negative response to this treatment she decided to consider bottom surgery in the form of an orchiectomy. For Ellen testosterone was poison and the idea that her body was producing so much of it weighed on her. Ellen’s medical coverage did not cover bottom surgery. However, Ellen was receiving care from a provider who understood that this was a burden so, “[Ellen and the provider] devised an illness that required an orchiectomy. So [she] got [her] orchiectomy, for free.” Campily, she added, “Mama doesn’t pay retail for anything.” The removal of her gonads allowed her to stop taking spironolactone and she now only takes the progesterone. For Ellen the orchiectomy was, “a blessing.” She declares that she doesn’t miss, “those bad boys at all, not even a little bit.” With her age and health issues she reports that this is the extent of her gender-affirming care surgeries. She notes this saying, “I have heart disease, lung disease, and arthritis. So why should I spend a lot of money, and no one looks directly at me?” She reports being happy and content with the extent of her gender-affirming care to date and only regrets that she did not realize and start the process earlier in her life.

Bottom surgery encompasses all surgical procedures that are enacted on the genitals of transgender patients as part of their gender-affirming care. Of all the
interventions currently being practiced by biomedical providers within gender-affirming care, this is the most invasive and carries the most risk to the patient. The procedures have been explained in the history section of the background and can include hysterectomy, vaginectomy, penectomy, orchiectomy, metoidioplasty, phalloplasty, vaginoplasty, among others. Transgender patients enter into these surgeries for a variety of reasons, including gender affirmation for the self, sexual reasons, health reasons, or other external factors (i.e., they are housed or potentially could be housed in sex-segregated systems such as group homes or prison where sex/gender may be determined based on genitals). 19 (79%) participants discussed bottom surgery. 11 participants had undergone bottom surgery; 3 participants were planning to get bottom surgery; 4 participants were considering bottom surgery; and one participant said they were not planning to undergo bottom surgery.

Bottom surgeries are not equally accessible, and the results of vaginoplasties provide more reliable and natural appearing results than those of phalloplasty. Phalloplasty carries a number of aesthetic and functional challenges as well as increased risks for side effects. While availability of phalloplasty procedures exists within the geographic region of the study, no participant had undergone this procedure giving a variety of reasons for hesitancy.

DBH: Are you intending to engage in any other gender-affirming care procedure or services?
[transman] I’m still thinking about, what do you call it? Vallo?
DBH: Phalloplasty?
[transman] Yeah, that’s the, I want to, but I’m, I’m nervous and anxious about that, That’s I think that’s the only thing really.
Metoidioplasty is a less complicated masculinizing procedure, but still involves a level of risk and may not provide one with the ability to engage as an insertive sex partner. Within the study, one participant expressed wanting this procedure, but noted the COVID-19 pandemic as a reason for delaying care. One participant seeking a less invasive but similar procedure stated,

[transgender man] I’ve, like, thought about, bottom surgery is too large of like a category. I’ve thought about specifically doing clitoral release. So not like, like the, this like, the, the least invasive version. Like the step, even before metoidioplasty, like that’s the only thing that, like, I’ve considered doing as additional gender-affirming care at this point. I, like, don’t want a hysterectomy or an oophorectomy. Just because I don’t wanna have kids, but I also like, [I] don’t fully know.

There was a stark difference among participants in those seeking bottom surgery as a masculinizing procedure and those seeking feminizing procedures. 4 participants had hysterectomies as part of their masculinizing gender-affirming care; while, 5 participants had vaginoplasties and 3 participants had orchiectomies as part of their feminizing care. When it came to orchiectomies and hysterectomies the primary cited reason for having these procedures was related to hormone levels (n=4). This was shown in the following quotes,

[transgender woman] I decided let’s get the testosterone gone. So, I had an orchiectomy and the year, the year, it’s been over a year and it’s just, for me, a blessing.

[transguy] You know, I was grateful to get the hysterectomy, but I felt a little pushed into it by my endocrinologist.

[transgender individual] I had an orchiectomy two, about, over a year ago to, cause my, they, they were having trouble lowering my testosterone, just wanted to stay high.

[transmasc demi boy] And the only reason really why I’m considering the hysterectomy is because of the effects of the testosterone on my cholesterol. So,
it’s like a health, to me it’s like a health concern and it’s like having that hysterectomy will allow me to decrease my testosterone.

When it came to vaginoplasty, participants were generally satisfied with their procedures even when they faced challenges or side effects. Side effects included scarring (n=1), pain (n=3), and challenges with dilation (n=2). Scarring was only mentioned by one participant who experienced keloids at the site of incisions noting,

[transgender individual] So, I’m very prone to keloiding, if we know what that is, and so that has caused like a lot that, that, so basically, like, that has caused like ridges around my surgical area. And so, when I put on specific, like, fabrics, it kind of looks like a bump, which is like causing me to like, freak out, like, in terms of my dysphoria.

This patient was able to receive dermatological support years after her surgery to address the pain and visual issues. She expressed a desire that her surgeon would have known the options for correcting this rather than leaving her with years of pain until she stumbled upon a dermatologist who offered treatment. For patients who experienced pain as a side effect the following descriptors were noted,

[transgender individual] nerve pain in my clitoris [sic] (the head of the penis) that feels exactly like a large rubber band snapping you on the clit/head-of-penis at full force.

[transgender individual] the pain that I’m experiencing is my nerves … it’s got kinda like that tingly burning sensation that comes from nerves.

[transgender individual]: is like a searing knife.

These moments of pain for two individuals are connected to the need for dilation.

Vaginal dilation is necessary for preventing the neovagina from closing up. This involves placing a vaginal dilator into the neovagina and leaving it there for a set amount of time. Dilation is required more frequently during the weeks and months following the procedure and then less frequently after healing. One participant found the dilation
requirements challenging to balance along with other needs which has led to a situation where they may need to return to their surgical team for revisions,

[transgender individual] I am closing up. It’s not my surgeon’s fault. I just, I don’t have, working 60 hours a week. I’m too, I’m too tired. I don’t have enough time to do it [dilation] three times a day.

The most common procedure for vaginoplasty in the United States is the penile inversion. Recently a new procedure has been adopted by a few providers and has gained a following among transgender individuals seeking vaginoplasty procedures. This is the peritoneal pull-through vaginoplasty via the Davydov procedure, which has been performed on cisgender women for decades, using peritoneal tissue to construct the neovagina rather than intestinal tissue or penile skin grafts. One participant describes the procedure as such,

[transwoman] when you look at the peritoneal pull-through, it’s, it’s a Davydov procedure on the back half and it’s a regular vaginoplasty on the front half, or vulvoplasty on the front half. So, instead of, you know, reusing parts from this area, they’re using parts from this area over here, and it’s still the same general procedure. And on top of that, the back half is a Davydov procedure they’ve been doing that since the 50’s on ciswomen who have vaginal prolapses problems and certain vaginal cancers.

The advent of this procedure appears to be starting to change some of the narratives around vaginoplasty by offering an opportunity to remove the penile tissue from the procedure. As some participants noted when describing why they were not going to get a vaginoplasty or a penile inversion,

[female transgender individual] I’m not going to get a vagina out of it. My penis is going to be inside out, and while it’s largely not useful to me at this moment. I fail to see making it go inside out.

[transgender individual] I specifically won’t be able to do penile inversion and enjoy my body, because it’s not, I can’t have what there. I can’t have the whole thing be used and be ok with my body, because I’m just going to see it as, it’s just
the same parts, we just rearranged them. … Another trans friend told me it was just pushing it all inward, and my brain went, oh no we don’t like imagery.

Penile inversion has been a gold standard for vaginoplasty for decades; however, the views beginning to be expressed regarding peritoneal pull-through and the ability to retain as little penile tissues as possible are gaining traction among transgender individuals seeking these procedures. The lack of providers performing these procedures and a lack of case studies will prevent this from quick widespread adoption, but as patient sentiment and demand increase, peritoneal pull-through may become the dominant procedure in the next couple of decades.

The narratives and views on the penis expressed by the participants in this study who mentioned the peritoneal pull-through are reminiscent of discussions of the social penis. Further research into this symbolic language and views regarding identification and social emphasis on penises is warranted. It may also explain differences in the rates of bottom surgery between transmasculine and transfeminine individuals.

Five individuals in the study specifically mentioned their bottom surgery as a factor in reducing their dysphoria. This was reflected in statements like,

[transguy] a huge area of dysphoria, for me, was around just the idea that I could get pregnant and so having a hysterectomy was excellent.

[transgender individual] My biggest experience of euphoria is to be able to go work out and not having, like, my genitalia get in the way. So, there’s just movements that I can do nowadays.

None of the participants reported regretting their bottom surgery or wishing to reverse it.

There were some mentions of gatekeeping by surgeons, and this primarily came in the form of body mass index (BMI) requirements by providers (n=3) or lack of
aesthetic input from patients (n=1). The views around BMI requirements are reflected in the following two quotes,

[transwoman] I tried to get in with [surgeon] at [hospital]. And when I call them to make an appointment for console [consult] for vaginoplasty, I was told that she wouldn’t even see me for a console because I weighed too much. … I know I weigh a lot, but I’m mostly muscle, like, not fat. I’m just heavy. And they didn’t care, they would not make an appointment for me, because I weighed too much, and that really pissed me off, like really!? Really!? 

[transgender individual] The only concern that I have currently is the use of BMI as a gatekeeping tool. I am not a very big person. I’m 5’8”. I’m 217 pounds, but by BMI standards I am obese, and because of that [surgeon] will work on me, but has said that he would be far more comfortable and would prefer if I dropped some weight.

Given the strong sentiments expressed regarding the BMI requirements, a fat studies focused exploration of the BMI requirements, impact, and views of these requirements from the transgender community should be explored. Larger-bodied and fat transgender individuals may be experiencing additional barriers to care, which should be explored in more detail.
Chapter 9: Other Procedures

Anne is a White transgender individual who did not reveal her age in the study. She had been coping with a lot of stress, which increased during the COVID-19 pandemic. As a result of the shutdown, she was unable to get her hair cut. She was regularly moving her long hair out of her face when one day her spouse suggested tying it back with a scrunchie. This was a defining moment for Anne. She reported having thought there was something different about her in her childhood, but the act of pulling her hair back into a ponytail led to her, “cracking moment,” when she realized she might be transgender. This hairstyle was something she had never been able to do during her life due to social expectations of being a boy. For Anne, this perceptual change was enough for her to come out to herself and subsequently her spouse and friends. Her hair was an important aspect of affirming her gender to herself, and a means of expressing femininity to others.

Many aspects of gender-affirming care can be enacted within biomedical spaces that are not part of the core procedures. Participants in the study mentioned medical tattooing (n=1), butt implants (n=1), vocal cord shaving (n=2), and facial feminization surgery (n=9) as some examples. While facial feminization surgery was not a major focus for this study (due to the lack of an equivalent procedure for individuals seeking masculinizing treatments) it nonetheless is an available treatment for transgender individuals seeking feminizing treatments. Of those mentioning facial feminization surgery only one had undergone the procedure; one participant said they were not interested in the procedure; two participants just discussed it as an option; and five
participants expressed considering or wanting this treatment. This procedure was often
mentioned as a wanted surgery because it is often classified as cosmetic by insurance
providers and finding ways to cover the cost can be challenging. The following quotes
reference the insurance or financial challenges to accessing this procedure.

[transgender individual] Going forward, I would like to find out if insurance
would cover facial feminization. That to me would be the next most important
thing.

[transgender female] OK, I’m aiming for the FFS, facial. It’s a little expensive,
but with this I’m aiming for. So mostly I’ve been just going to support groups,
talking to people, getting to know how they can help me as a female trans.

[transgender man] In an ideal world. We’d stop calling like facial feminization
surgery something that is like cosmetic for trans women. Like, it’s certainly has a
cosmetic effect, but it is like a, like for some people, it is a necessary surgery.
Like, I think, it would look like changing the language from cosmetic to
medically necessary.

[transgender individual] I did try to get facial feminization surgery, but then I
look more into the Medicaid insurance package and they don’t cover it, because they,
because that it only affects self-esteem.

The participant who had undergone the procedure noted how the surgery
impacted her ability to be perceived as a woman and reduce misgendering.

[transwoman] I haven’t been misgendered by, like in public, by a person in a
couple years since I, since I had facial feminization surgery. And so, you know,
that it makes a difference. It makes, it makes you not so damn skittish about going
out and doing things and meeting people and living a normal life, and having a
social life.

The most common ancillary medical procedures mentioned were those that dealt
with hair. This included preventing hair loss and especially electrolysis. The theme of
hair included both body hair and the hairstyles worn on the head. It was interesting to disentangle the concept of hair among participant responses. Sixteen participants directly mentioned hair as a critical element of their gender journey. Nine participants identified hair, both body and that on the head, as a source of dysphoria in statements like,

[transgender individual] Having to let my facial hair grow in order to go for electrolysis is like the worst. I hate it. Especially, because I, this is my natural hair color [dark] and my facial hair is the same. Most of it is now pretty much white, at least from the laser, but this whole area grows in very dark and I usually have to let it go for two or three days before I go in for electrolysis, and that’s very triggering for me.

[transmasc demi boy] And so having short hair is actually super dysphoria inducing for me, and since I had to cut my hair recently to like restart my hair journey, I’ve had short hair, and it actually is super, like, I actually try not to look too much as my hair, because it causes me a lot of dysphoria.

[transgender individual] I used to experience real bad dysphoria from my body hair. I couldn’t look at myself in the mirror. I in, in the times before I came out, I wore ankle length pants, wrist length – you name it, anything to cover up as much skin as possible, because I couldn’t, couldn’t stand to see all the body hair.

Eight participants mentioned the impact of gender-affirming care on hair, particularly around testosterone's effects on facial and body hair growth (n=5) and the use of electrolysis to remove hair for feminizing treatments (n=3).

DBH: Was there any part of the gender-affirming process that triggered dysphoria for you?
[trans individual] Yes, in a way. I think, obviously, because I haven’t had top surgery, all the chest hair I’ve gotten made it a lot weirder to look at my chest. So, it has worsened that.

[transguy] I honestly had no sense of how I was going to handle being, like, a pretty hairy dude. So, it’s, like, I could tell. It’s, like, I’ve got those genes. I don’t know how that’s going to be, but beyond that I think, especially early on, I was just really surprised at how much of a difference it made for my mental health.
Electrolysis is often required by surgeons before a patient being cleared for bottom surgery. This prevents hair growth in areas where it would be problematic, such as inside the neovaginal canal. In this study, nine participants mentioned electrolysis indicating a desire for the procedure for becoming one’s true self (n=7) or as a requirement for surgery (n=3). There was overlap of one participant who expressed that electrolysis was both for personal satisfaction and for surgery preparation.

[transgender individual] I have undergone quite a bit of full body laser, and I really don’t grow much hair now. But, fresh out of the shower, after I’ve shaved what little stubble my face still grows, I see [participant first and last name] in the mirror and it just, it’s really nice.

[transwoman] All I’ve had is the hair removal, although, you know, having no chest hair is extremely, you know, extremely good. I had facial hair removal too, but it, I didn’t complete, so I still have to shave unfortunately.

DBH: Were there specific parts of your gender-affirming care process that you think were most effective at reducing your feelings of dysphoria?
[transgender individual] body laser. I come from a long line where all the men in my family are very hairy all over their torsos, and I followed suit. Getting all of that removed was terrific. It was, I was over the moon about it.

Hair is an important aspect of one’s social skin (Turner 1980) and is a common expression of gender in U.S. culture. Hairstyle and shaving patterns are heavily dictated by social expectations and values attached to an individual’s gender. As a result, controlling one’s hair is an essential element of communicating one’s gender identity to others, and some hair is easier to control than others. As noted in the participant quotes above, fast growing, dark, or thick facial hair may cause a transfeminine person distress due to the presence of stubble and the expense involved in accessing electrolysis; while the ability to grow one’s hair longer to perform femininity might take time it presents fewer obstacles to achieve. Controlling hair can be done through shaving, allowing hair
to grow, and managing hairstyles. It can also involve biomedical professionals to prescribe hormone treatments, perform electrolysis, or even to treat the effects of baldness. However, hair is managed, hair is a crucial element in communicating gender identity in society and is interwoven in both the biomedical and individual practices that can be enacted as part of gender-affirming care.
Chapter 10: Clinical Setting

John is a White transman in his thirties, who has at times also identified as genderqueer. John has been seeking care from a hospital that has an LGBTQ health network which it markets to the LGBTQ community as a safe and affirming space. John calls the number for his gender-affirming care visit to set-up an appointment. The automated attendant refers to the clinic as a women’s health center and further in the messaging as a women’s clinic. John attempts to make light of this, but reports feeling that he has to mask his feelings when accessing this clinical space. He feels disappointed, unwelcome, and alienated, describing a sense that there are “so many other ways [the clinic] could have done this that would have been better.” For John, this lack of consideration feels like they, “just slapped some rainbows on a logo and, you know, want your dollar.” He reflects that he feels even a cursory walk through from a transgender identified individual would have flagged how the use of women’s clinic language for a gender-affirming care provider’s location would have been flagged as problematic. John notes that the location, while marketed as part of the LGBTQ care network for the hospital did not have signage or posters related to LGBTQ care. It was just a, “very stark room...no rainbows, no flags, nothing that we commonly use in the community,” to show a space is designed or designated as safe for LGBTQ individuals. John even suggested that the clinic doesn’t necessarily need to be renamed, but the phone line could be
set-up that LGBTQ network calls are answered in a different manner so as not to trigger patient dysphoria.

In *The Presentation of Self in Everyday Life*, Erving Goffman (1959) discusses the ways in which interactions exist as social and cultural scripts. Goffman describes social interactions as occurring in regions, a front region which is where the action takes place, a doctor’s office, for instance, and a back region where one does not have to put on pretense, outside of that social space. Goffman describes the region as "any place that is bounded to some degree by barriers to perception (106)." These boundaries may be physical such as walls and windows, or bound by other less tangible barriers, such as time and virtual space. For this study the primary region of social interaction is the clinical setting. In most cases this was a doctor’s office. Due to the COVID-19 pandemic, this region at times was defined within the realm of a video conferencing call which served as a virtual proxy to the medical office defined by barriers of time and the connection of the video and audio devices over space.

When discussing the clinical office, one may see the boundaries of walls, doors, and windows as fixed and impenetrable. However, biomedical care does not exist in a bubble separate from the social and political climate of the broader society. Policies, regulations, insurance, and laws can be present as implicit actors in social interaction. Implicit actors may transcend the perceptual boundaries such as auditory or visual to engage among human actors within a defined social space, such as the medical office. Some may consider these actors to be part of the preparation of the performance; however, their ever presence within the delivery of gender-affirming care suggests that
they are more than precursors and are directly acting within the social space of the medical office.

Over the past couple years, a spate of anti-transgender laws has been proposed. According to an article in the *New York Times* (Astor 2023), over 150 bills in 25 states have been introduced to limit or curtail transgender individuals’ rights to access education, employment, public accommodations, and in a few extreme examples their very existence. The most extreme of these laws aim to “define sex as immutably set at birth (Mississippi)” or classify “‘transvestite and/or transgender exposure’ to minors as obscene (West Virginia).” Right-wing legislators and Christian conservatives heavily drive these bills.

One-third of participants (n=8) mentioned an impact from implicit actors, other than insurance, on their clinical decisions within gender-affirming care. Half of these individuals cited political climate (n=4). Other implicit actors included religious activists (n=1), family (n=2), and capitalism (n=2). Capitalism was only tagged here if directly mentioned. Insurance and financial barriers will be discussed in the next section, and if included as capitalism would greatly increase this number. Some examples of these concerns can be seen in the following participant quotes,

[transman] I look at these, like Alabama and Florida, and especially Alabama. What they’re doing in Alabama [Alabama banned gender-affirming care for youth]; I’m like what the fuck? Are you like, what are you all thinking? You know, how do you? How do you, how do you feel like you have a right to tell people what to do with their bodies?

[transfemme demigirl] Externally, it’s a bit different. Because, of like, a lot of things going on politically and, and with the pandemic and seeing, seeing. I don’t have a lot of hope for the future with, with, not just the country, but especially like kind of like, the state of [State], and stuff. I’m kind of, so I have a lot of
anxiety about like, about, you know, like, I mean, Like I just, just. Yeah. … And just the amount of misinformation, hatred that’s just out there and just the complete, like, lack of, like, understanding and, and like adequate measures by like basically, like, anyone like in political office is just, just incredibly depressing, especially on the economic like, like, like sphere of things.

[transguy] Especially with all of the [specific proposed state law restricting trans rights] hearings, and all of that. And all of discussion about well, kids don’t know who they are. I wish I had access to this information sooner rather than later. Because, you know, trying to back-end fix a process that never should have done the way it did in the first place is just so much harder.

[transgender man] but they [parents] said that they wouldn’t support my college education if I tran-, if I like medically transitioned in any way, and so they were like, you can wait until you’ve graduated with your bachelors, or we cannot pay for it.

External implicit actors were not always framed in negative ways. The role of transgender knowledge shared by peers and transgender activists will be explored further in a later section, but is a crucial component of the patient provider interactions within gender-affirming care. Additionally, two positive culturally relevant references were brought-up by participants. These came in the form of references to the televisions shows Jeopardy! (1984-Present) (n=2) and Ru Paul’s Drag Race (2009-Present) (n=2). Ru Paul’s Drag Race, is a queer television show hosted by gay icon Ru Paul. The show has been heavily criticized for its early exclusion of transgender individuals and its handling of content that some transgender viewers found offensive. However, the show has remained a favorite among the broader LGBTQ community including transgender individuals for its highlighting of drag culture and support in challenging gender norms in society. The study participants who referenced this program did so by citing Ru Paul’s catchphrase, “If you can’t love yourself how in the Hell you gonna love somebody else?”
as a guiding principle in their lives and their gender journey. The television show *Jeopardy* entered into the transgender discourse during this study due to transgender contestant, Amy Schneider, who was currently competing on the show during a portion of the interviewing for this study. Amy Schneider became a celebrity contestant and boasted one of the longest winning streaks on the show and the highest-winning woman contestant. For transgender individuals, she symbolized a much less sexualized image of the transwoman and read as intelligent and average. One participant relayed their interaction with seeing Amy Schneider on *Jeopardy* as such,

[transgender individual] I often think to myself that if I were younger, I would do it [gender-affirming surgery]. I don’t know if you watch Jeopardy or not, DBH: Well, I watch clips of it, because I don’t have cable.
[transgender individual] Well the only reason, oh wow yeah, DBH: I hear you on that.
[transgender individual] But there is currently a transgender woman, I don’t know if you are aware of that or not.
DBH: And she is doing quite well.
[transgender individual] Yes, over a million dollars now, Amy Schneider, and I thought, oh my gosh, she’s trans. You know, by looking at her you can just kind of see that there’s, but she did wear a nice pearl necklace all the time. … I still think back to Amy Schneider, to be, there were a couple of other older people at the [transgender support group] meeting that, who were in a management type position that were able to somehow deal with all the issues being trans and you know, to be able to have your work be able to accept you for how, who you are, and accept you in realizing that you have a lot of other things that are talents that you can provide and do in your life.

Implicit actors may come in many forms, but do not remain in the rear region.

Rather, these invisible actors are not bounded out by the constructed barriers of walls and time and can have major impacts on the social interactions and negotiations within the clinical space. One of the most prominent of implicit actors in the U.S. clinical spaces engaged in gender-affirming care is of insurance and money.

**Insurance**
The healthcare system in the United States is largely modeled as a business with capitalist interests. The U.S. is the only country in the developed world that does not have universal healthcare for its citizens. This has necessitated the creation of insurance markets which serve to disperse the financial burden of healthcare across individuals who buy into these plans. The Patient Protection and Affordable Care Act which was enacted in 2010 has sought to reduce the number of individuals without insurance by making individual markets more financially accessible and requiring individuals to have insurance coverage or pay a fine. Employer-driven insurance plans, Medicaid, and Medicare remain. Healthcare systems and insurance markets remain driven by profit margins. This financial element may dictate the types of services and types of patients who are eligible to receive services. The ever presence of financial constraints and insurance impact the care delivery in the U.S., especially regarding gender-affirming care which remains under-covered.

Within this study, the role of insurance as an implicit actor for gender-affirming care was mentioned by 21 participants. Of these participants, 20 reported that insurance coverage or costs were related to delayed or indefinite postponing of procedures. Only two individuals noted insurance as a positive facilitator to their care, one of these attributed this to having a good plan and the other to just gaining access after a community-based clinic assisted them to get on Medicaid. The following quotes were expressed when discussing insurance challenges related to accessing gender-affirming care,

[transguy] The cost of things has definitely put me in a different financial spot than I would have been if I didn’t have to pay for two surgeries. And, you know,
pretty good insurance for medications that hasn’t been a huge burden, but you know, the place I was able to find top surgeries is going to be out of pocket.

[transfemme demigirl] I would love, like you know, laser hair removal to be covered by like Medicaid and, like you know, like just in general because I feel like, I mean that is, that is, that is, that’s like the big remaining source of dysphoria I have is with my facial hair mostly because it’s just, you know, it still grows.

Insurance markets in the U.S. are not detached from employment and nine participants brought this up. The primary challenge was unstable work or changes in work, which led to changes in insurance coverage (n=6) and three individuals delayed care until they attained employment that offered insurance coverage with gender-affirming care provisions. This enmeshment of employment, insurance, and healthcare access can be seen in the following quotes,

[transman] I actually never came out at my workplace. I worked at the same workplace for eight years, and I was laid off just at the holidays last year, and I never came out to them because, I didn’t want to deal with it. It wasn’t a field that I wanted to work in for long term or anything. And I, but I had really good health care with the, and a lot of seniority built up and, which I utilized once for a transgender surgery and was utilizing for transgender care. But and I was hoping to utilizing maybe again this year, which obviously isn’t going to happen for me.

[transguy] I could not start until I had a fulltime job that, you know, afforded benefits and I could like afford that shit. So that did not start until the fall of 2014 when I got my first [fulltime job].

[transgender man] I was doing test [testosterone] pellets when I was on [insurance] and then I got a job at [retailer] and their insurance wouldn’t cover it. And then, when I left [retailer] I got on [insurance] and, and actually I wasn’t taking testosterone, and like I took myself off because I just got tired of dealing with it [insurance issues].
Healthcare providers and insurance companies are rarely working toward the same goal. Providers make their money by increasing output and engaging in more complex procedures and insurance companies as payers make money by reducing financial risks and paying out less for care. This can create interesting situations where healthcare providers act as facilitators by navigating their patients' insurance access barriers. This role, occasionally, taken by providers was mentioned a little over a third of participants (n=9). The following are ways in which the patients described this,

DBH: Did [hospital] do your surgery or did they coordinate that out? [transgender woman] [Chuckles] I’m laughing because they don’t do gender-affirming surgery.
DBH: Yeah, I knew that, and so I was just, wanted to check and see. [transgender woman] So we devised an illness that required an orchiectomy. So, I got my orchiectomy, [researcher’s name], for free.

[transman] It was a lot of help from [patient care coordinator], because she was able to get my, my top surgery partially paid for. And again, it was basically just the surgeon wording things a certain way.

[transgender individual] And then she was also like, because it’s painful and like, I don’t know what the word she used, like inconvenient in your day-to-day life, most insurance will cover it and I was like, fantastic.

Insurance markets are complicated for patients and providers to navigate and are often tied to fulltime employment. Regardless of the types of insurance, challenges to coverage for gender-affirming care exist despite the positive changes discussed in the background section. Some patients and providers have found ways to navigate the red tape. However, delays in care and lack of coverage continue to present challenges for transgender patients seeking gender-affirming care.
Medical interactions are often understood to be discussions and choices made between patients and providers in the security and privacy of the clinical space. However, the role of implicit actors such as politics, hospital regulations, insurance, and capitalism among others are regular factors in the enactment of care and are not bounded out by the constructed barriers of the doctor’s office.

**Provider’s Office**

Within this study, most participants received their care from clinics specifically identified as targeting and serving the LGBTQ community (n=16). The remaining participants received care from private providers (n=3), mainstream clinics (n=5), or community-based healthcare organizations (n=1). Patients tend to seek out providers known in the community for providing the desired types of care with minimal gatekeeping. This information is gained from other transgender individuals who have previously sought these procedures.

Twenty years ago, the research location had an unofficial LGBT clinic. The clinic was a drop-in testing location for HIV and other sexually transmitted infections. The waiting room of this clinic contained pamphlets and information aimed at LGBTQ patients, and had queer publications throughout the waiting room. Sometime over the years, this clinic setting transformed. As more providers, in the area, specialized in LGBTQ healthcare, insurance coverage broadened, and health care systems carved out explicit spaces for LGBTQ healthcare delivery, the delivery of care came to reflect the mainstream biomedical systems and no longer (aside from being identified as an LGBTQ clinic) a distinctly queer space. This is an important change as 13 participants mentioned the lack of LGBTQ information, pamphlets, magazines, or other physical indicators.
within the clinical space, of these ten were receiving their care from an LGBTQ specific clinic. I inquired casually with colleagues who worked in two healthcare systems and was informed that at one hospital it was hospital policy not to have things on the walls in the clinic rooms. The other had no policy, but thought maybe COVID-19 was a factor in the lack of items in the clinical space. If the provider did not state that the space was an LGBTQ healthcare area, there would be no way for anyone to know the difference from any other clinical space. Participants described these clinical spaces as sterile and plain. The following quotes are emblematic of these descriptions,

[transman] The actual meeting, or waiting space was just so big and generic. There, there really wasn’t much of anything, like even signage for other departments or, you know, posters about your other types of health or anything. It was just very, very stark and in the room, definitely nothing, at least, eye-catching, you know, no rainbows, no flags, nothing that we commonly use in the community to kind of iconically or, or designed-ly signify, you know, there’s something for us here.

[transman] It was very plain, very plain. Very, like, if I could say bland. Nothing LGBT, resources like, no. Nothing on the walls, no magazines, no buttons worn.

[gay tranny] [Doctor’s office] I suppose, like, like, a dentist office. ... It’s too plain, like a lot of medical stuff, like, Having things, like, all white.

[transmasc demiboy] It’s like an interesting environment and, and I guess this didn’t really come up the first time, but it’s like, it’s technically like one of their [LGBT care] clinic locations, because like, they have the people [LGBT health care providers] housed there. But when you go there, there is no, there’s no queer shit to be found. It’s just like a hospital. It’s very sterile.

The hospital systems represented in the study all serve LGBTQ patients for gender-affirming care in some capacity; however, except one community-based health organization, there were no indicators within the clinical space to make the space read as
queer to patients. All of the hospital systems had LGBTQ care spread across their physical sites and often defined by the specific providers that a patient was going to see. The challenge is that these spaces are not dedicated solely to LGBTQ healthcare. Only the given provider occupying that space at the time of service delivery serves to demarcate the location as queer; remove the provider and it could be any clinical space in the U.S. For some this would be enough to make a space queer, but for others the presence of LGBTQ indicators provides a reassurance or acknowledgement of the patient population and types of care enacted within the space. Three participants mentioned that one or more members of their care team had a pin or a rainbow themed accessory, which they read as the provider indicating their work with and support of LGBTQ patients. One patient summed-up the LGBTQ care network situation in hospitals as such,

[transman] [hospital] has dispersed their [LGBT care] clinic, is actually kind of called a [LGBT care] network. So, my understanding of how this system works, and that, that is on purpose to have doctors stationed throughout the community because, [hospital] is throughout the community as opposed to really designating one spot as the [LGBT care] clinic. And you, everybody goes there for all of your services. And for some people it might be really convenient, but for other people it might be really far away. While that’s a very noble idea, then the reality is, is that you end up with things like this [bad situation], where it’s a practice designed around a whole different kind of care.

The spreading of LGBTQ healthcare across hospitals rather than holding dedicated space to serve these patients has also led to challenges around the nomenclature of hospital departments. Sahmoud, Hamilton, and Pope (2022) note that many clinical spaces carry gendered names such as women’s clinics, or are heavily gendered such as gynecology and urology. These gendered naming systems may cause dysphoria for patients or lead to mistreatment from staff and/or other patients. Five participants noted challenges around accessing care due to being triggered by these naming systems, or
being misgendered or stared at in the waiting space due to gender expectations of the department.

[transman] The phone call to set up this appointment was wretched. It was several layers deep in a phone tree, and every part of the menu referenced women’s health or women’s clinic. At no point in the automated menu did it even mention the [LGBT care clinic]. Besides being very difficult to navigate to set up an appointment for the specific doctor I was referred to (for anyone), for myself as a trans person it was very dysphoric and unwelcoming.

[transgender individual] My primary care doctor also does [pap smear] so I don’t have to go to a gynecologist, which just sitting in an office that said women’s health or gynecology makes me sick.

As diagnostic tools and treatment standards can be slow to change, so too are the structures of hospital departments and the divisions of medical practices. Integrating gender-affirming care into the broader hospital landscape will require rethinking how various areas of practice are identified and how staff are equipped to handle increasingly diverse gendered patient populations. This rethinking will be explored further in chapter twelve.

Clinical spaces are often designed to be sterile, clean, and white. This generic space is designed to uphold the ideal of medicine as clean, precise, and driven by scientific evidence rather than social and cultural influences. These spaces are designed to appeal to biomedical natives, but when working with traditionally marginalized populations, indicators tell patients that a space is welcoming and safe for them. The boundaries of the clinical space only allow the patient to be present as an object of medical treatment or study. The lack of LGBTQ identifiers serves only to further remove
the idea of the patient as a person and further institute medicine’s clinical gaze emphasizing the active role of providers and the passive role of patients.

**Getting to the Clinic: Arrival, Receptionists, and Waiting Rooms**

Doctor’s offices are situated within medical buildings where patients must enter through specific entrances and move through greeting systems and receptionists to arrive at the correct clinical department. After checking-in a patient is rarely admitted to go directly to the doctor’s office, but must pass time in a waiting room that contains other medical patients. While these spaces are not locations of care delivery, they are part of the overall boundaries of the care system and can have enormous impacts on patient experience and comfort when they are called to enter into the doctor’s office.

The first person in the medical center that patients interact with is generally the receptionist. Sixteen participants mentioned these types of interactions and it was evenly split on whether their interactions with receptionists were smooth and regular (n=8) or awkward and negative (n=8). The designation of a provider as part of an LGBTQ care network did not seem to have an impact on whether the receptionist or other hospital staff were adequately trained or acquainted with how to interact with transgender patients. In positive cases participants described their experience with receptionists as “professional,” “helpful,” “kind,” “simple,” “polite,” or “neutral.” When it came to more negative experiences this was usually a result of misgendering, deadnaming, or uncomfortably questioning a patient. These types of interactions can be seen in the following patient experiences.

[transmasc demiboy] Despite all the things that, like, my chart and everything said misgendered me when they called and so I think they just saw, like, oh you want
an estimate for a hysterectomy; therefore, you must be a woman and we must use she/her pronouns, and it’s like, no. So, like even in like these spaces where you have like these [LGBT care] clinics, it’s like, you can still run the risk of people just being. It’s not malicious. I don’t think. It’s just ignorant. But I almost called back to be like him. I must, I must correct you and educate you on why what you are doing is incorrect. But I resisted because I didn’t have the spoons. [spoons here refers to spoon theory as understood in disability and chronic illness circles and coined by Christine Miserandino in “The Spoon Theory” published on But You Don’t Look Sick (2003). It describes having limited or finite mental and physical resources (spoons) and the ways one makes the decisions on where to expend these resources, even on seemingly mundane tasks. The individual stating that they did not have the spoons here, means they did not have the mental or physical energy to engage in addressing the misgendering and to educate the staff member.]

[transwoman] The receptionists. They were nice. One of them mis-gendered me. … Being mis-gendered wasn’t unexpected so it didn’t affect me much.

[transman] When I used to get mammograms, you know, outside of my doctor’s office. And they call, you know, like when I go into the receptionist and they said, they’ll look at me. I’ve had this done several times. Are you sure you’re in the right place? I’m like, you know, if I was at the grocery store, I would be like fuck this. I’ll go somewhere else. But, no, this is, that this got, gots to do with preventative care here, so fuck you!

Negative experiences with the receptionist may set the tone for the subsequent wait and medical visit, they may also contribute to distrust in medical systems that advertise specifically to LGBTQ patients, but whose practices are not uniform across their staff and medical departments.

Receptionists are generally located within or adjacent to waiting areas or rooms. These waiting rooms are locations where a provider’s various patients may exist in the same space. While social decorum in medical waiting areas is often akin to that of elevators and includes minimal interactions with others and attempted deflection of eye contact, these locations were not without challenges for transgender patients. Waiting
rooms were described as having “a lot of space to spread out,” “huge,” “beige and neutral,” and “seating is spread out.” The general descriptions of the waiting room were representative of the following participant response to the prompt *What was the waiting room experience like?*

[transgender individual] Extremely unremarkable, a mix of normal people and people frustrated about covid policies.

However, for one sixth of the participants (n=4) the waiting room was an area of extreme tension or discomfort. All of these participants received gender-affirming care in clinics with gender designations such as women’s clinics, gynecology, or urology departments. The result is that their gender expression and identity stood out from the other patients in the waiting room. These experiences are reflected in the following descriptions,

[transgender woman] And sometimes I get the fish eye. Which is, if you don’t know, what that is, another word is the stink eye from some of the old [men], but I don’t care. I look right at them and smile and say good morning, but this time there was no one giving me the fish eye at all. … They make me sit and wait and wait and wait and people glower at me in the lobby, because that’s where everyone passes through.

DBH: Were there any parts of gender-affirming care process that triggered dysphoria for you?
[trans man] Yes, the, the, definitely the, the hysterectomy. That was a lot, that was a lot especially at [hospital] because the GYN clinic, at the time, was attached to the women’s health clinic. So, I had to not just continuously go into the women’s health clinic; to like sit in the waiting room and be like surrounded by all these women looking at me and wondering why I’m there and, you know, things like that. Like, hey there’s this guy sitting here and you know I, I actually was. Like, there was a time where a lady actually told the, the receptionist that she was uncomfortable with me sitting in there. The receptionists of course knowing who I was at the time, and that I had an appointment; I think she, you could tell on her face she was stuck because, she didn’t want to out me. But she also didn’t want to, you know, keep this, this other woman, this other patient feeling uncomfortable. So, she was kind of stuck and didn’t know what to do. So, So, I ended up just getting up and walking out. I went to grab a snack or something like
that, and, you know, walk around the halls until my appointment. But I had to like sit in that, and that’s just in the waiting room.

[transman] I would have to go to gynecologist office, office in, you know, in a woman’s clinic and you know people who, you know, I know those people looking at me, but, you know, I wouldn’t even really pay attention to it. But, like they are like, like these people are really just like, don’t know why I’m here at all. You’re looking at a man, but like, this is a woman’s clinic and like sometimes, you know, it made me laugh sometimes because, for me I just, you know, I can’t let people, when it comes to my medical issues and all that other stuff, I can’t let people stray me away from that.

[transgender individual] There were a bunch of older men who I was wondering if they were wondering what I was doing there. … The rest of the patients in the waiting room made the experience a bit uncomfortable since I was the only transgender person in there and they were probably all there for different reasons.

Participants who sought care in gendered clinical spaces only raised these waiting room issues. In more generalized medical departments and practices waiting rooms are more likely to contain individuals of various gender identities and a transgender person’s presence will be less likely to be seen as out of place or draw undue attention.

The interactions with receptionists and the waiting room are part of the overall clinical space and serve as an intermediary space. The waiting room blurs the biomedical and the public by overlapping these domains of social interaction. This can create conflict for transgender patients whose identities remain highly regulated and under attack socially and politically. This can be expressed by looks or comments from other patients or be highlighted through interactions with undertrained reception staff who might deadname or misgender these patients. These interactions may set the tone for subsequent interactions with medical providers. While the design of the doctor’s office attempts to assert itself as apart from the social and political, it cannot fully devest from the impact
and influence of these systems of oppression when it comes to gender-affirming care, and in some cases appears to further erase the discourse around queer spaces, transgender rights, and bodily autonomy.

This section discussed the region where the social interactions between the human actors, providers and patients occur. The next section will explore human-to-human clinical interaction within gender-affirming care.
Chapter 11: Gender-affirming care and Biomedical Practices

Ariel is an Asian transgender individual in her twenties. She first realized she was transgender after meeting a transwoman and listening to the transwoman’s experiences and feelings. For Ariel, these resonated with her own feelings and experiences and she would learn about hormone therapy and how to initiate transition. Ariel would eventually access gender-affirming care with providers that she found through word of mouth. When asked about how she learned of the options available to her she noted that the only education that she got before entering into medical care came from other trans girls and usually information from trans elders. Through these individuals Ariel was able to get her questions answered around the procedures other transfolk received and the effects and impacts of those procedures. She notes that, “I don’t know where I would be if I didn’t connect with other trans women and hear about their lives and what they do.” Ariel attempted to do some research through search engines, but could not find reputable resources. She notes that she could not find a .gov website with vetted information on gender-affirming care. The information she was able to gain from other members of her community was invaluable in learning about gender-affirming care experiences and expectations. While still in her twenties, Ariel notes that she is now seen as a trans elder, having gone through various treatments and surgeries. She has been able to share her own experience and knowledge of the gender-affirming care systems with transgender
individual who are earlier in their gender-affirming care process. She prides herself on being able to provide this information and support others in accessing and navigating their care.

In this section, I will highlight how the practices enacted in gender-affirming care unsettle some of the core concepts of modern Western biomedicine and add to the critiques of these concepts within medical anthropology. These practices challenge concepts of mind/body dualism, medical practice hierarchies, the medical gaze, medical authority, and docile patient roles. This positions gender-affirming care along with various other medical debates that center on patient experience, patient bodily autonomy, and combining mental and physical health. Debates whose outcomes have the potential to reshape the ways in which biomedicine is practiced and understood in the U.S.

The division of mind and body as distinct entities was established in Western thought by French Philosopher René Descartes (2008). Descartes set to show that the human soul, now understood as the mind, and the body were separable and thoughts were non-physical. This is known as cartesian dualism and has been a core element in the practice and understanding of Western biomedicine to date. As a result, medical practices are often separated into mental and physical care, insurance providers separate coverage criteria for physical and behavioral health, and stigma around accessing mental health services continues to be a factor in the U.S.

This understanding of mind-body dualism has remained intact despite additional information on the integration of mind and body in health. This has been highlighted in anthropology when looking at topics such as trauma (Pandolfi 2007), stress (Scheper-Hughes 2007), and other emotions (Kleinman and Kleinman 2007) in relation to various
ethnomedical understandings of health and wellness. Pandolfi has documented the ways in emotional experiences among women in a southern Italian village were exhibited and expressed as physical ailments. She refers to these somatic descriptions of feelings as *symbolic physiology*. Similarly, Scheper-Hughes has documented a folk condition, *nervos*, which is experienced by poor and marginalized communities in Brazil, among other cultures, as a physical embodiment of stress experienced by these individuals. Kleinman and Kleinman have documented how depression is characterized as a mental illness in Western medicine and contrasted it against other cultures where depression is understood as part of a somaticized condition affecting the physical body, while also demonstrating that somatic elements are in fact also part of the Western understanding of the condition. These anthropologists have raised the question about the separation of mind and body in medicine. Current biomedical trends are beginning to incorporate a model of health that is more integrated when it comes to mental and physical care.

This shifting narrative of an integrated mind and body is becoming reflected in some mainstream medical systems. A recent commercial by Cigna (2018) featuring actress and singer, Queen Latifah, shows the performer stuck in traffic. It then cuts to her in a kitchen as a turkey dinner kitchen disaster as she talks about how stress can manifest as mental health symptoms, but also physical health symptoms and encourages the public to discuss their emotions, in addition to physical indicators, with their primary care provider. The tagline “body and mind, Cigna, together all the way” ends the segment. This shift may be driven by current research on mind and body connections and/or it may be driven by neoliberal medical markets which are becoming more competitive with
patient satisfaction rising as a quality control measure. In either case, the reintegration of mind and body as impacting one another is being explored within biomedical practice.

Gender-affirming care is another example of this integration in biomedicine, as physical medicine is called upon to treat what was classified as a mental health concern and neither field of medicine can provide the full range of treatments as currently practiced. This practice recognizes a connection between the individual’s mind and their body and seeks to treat both through biomedical practices. In the current practice model, an individual receives a diagnosis from a mental health provider before engaging in physical health services. The WPATH Standards of Care uphold this process (Coleman et al. 2022), hospital policies, and insurance requirements. This model serves to keep the patient from being the authority on their own physical health needs and positions the mental health provider as an expert who must examine and diagnose the patient. In doing so, the process also disrupts a hierarchy of prestige in medical practices between various providers, with surgeons at the higher end and mental health providers at the lower end (Creed et. al. 2010, Rosoff & Leone 1991).

Transferring authority to the mental health provider to authorize pharmaceutical or surgical interventions disrupts this perceived hierarchy of prestige and power across interprofessional categories within biomedicine. Some private cosmetic surgeons accepting only cash payment may use an informed consent model and thus, bypass insurance requirements for mental health letters. However, due to costs and accessibility issues transgender patients are more likely to seek their care from systems that accept their insurance, which may require adherence to the WPATH Standards of Care (2022) model.
In French philosopher, Michel Foucault’s work, *The Birth of the Clinic* (1994), a history of the development of medical systems is presented which shows that ways in which formalizing the practices of biomedicine was influenced by capitalism and the medical gaze. The medical gaze is one that looks at the human body as an object or series of objects which can be worked upon rather than as individual persons. The concept of the medical gaze has been used within anthropology and social sciences to explore the ways in which biomedical providers understand and interact with their patients. The establishment of the clinic as an authority in medical practice and the objectification of the body led to a reduction in the role of patient authority as a diagnostic tool in clinical space. German medical historian, Barbara Duden (2007), in exploring eighteenth-century medical literature on birth, finds that female patients and male doctors had differing understandings of their symptoms and had to come together to enact biomedical treatments. In biomedical practice patient complaints and experiences of symptoms are taken into consideration, but a medical professional must verify an indicator to begin treatment. This emphasis on provider authority over patient experience and autonomy has been a central feature of gender-affirming care, and one that is challenging for patients to support due to the indicators being set around the very patient experiences that the tools seek to replace. Physician, Stanley Reiser (2009) has mapped out the historical integration of technoscientific tools into the practice of medicine and how this practice led to the replacement of patient narratives with diagnostic tools and medical provider observations. Medical training engrains these ideas into providers, such that, even queer providers may fail to incorporate identity issues and cultural knowledge into their
practice of medicine, as observed and documented by anthropologist William Robertson (2017).

As described in chapter five, medical systems and practices are large and built on institutional knowledge that can be slow to change (Douglas 1986). Updating diagnostic criteria, care standards, and protocols takes time and often must pass through several lengthy processes. These processes which often require large amounts of empirical evidence gathering do not allow for dynamic changes. Within gender-affirming care this leads to patients learning the criteria and molding their narratives to meet outdated indicators in order to access care (Prosser 1998). This results in many providers not realizing that the criteria are flawed and adds more false confirmations of the criteria to the medical discourse. Those providers who have noticed the flaws and are engaged in assisting patients in accessing gender-affirming care may provide letters with minimal questioning. They may also create alternative diagnoses to meet the same desired result for the patient or push on insurance providers to authorize an exception for individual patients. Many of these practices are not captured in the medical literature and may lead to disciplinary action against the providers if made public.

Transgender patients are highly knowledgeable about the practices, procedures, and pharmaceuticals that are central to gender-affirming care. Cutting edge knowledge and procedures are most likely to be spread among the transgender patients themselves before being known to their providers. Various models of care seeking have been explored in medical anthropology, two of which include lay consultation as an important element to care decisions of patients. Chrisman (1977) presented a fairly linear model that moved from symptom definition to lay consultation and sickness role then to
treatment seeking and adherence. Alternatively, Kleinman (1980) has shown care seeking behaviors based on various decision points the process of identifying symptoms and seeking appropriate care. This model included traditional and alternative medical treatments and showed the influence of lay consultation and perceived effectiveness of treatment.

As was the case in Anne Bolin’s (1988) ethnographic work in the 1980’s, in this chapter my research reveals that transgender patients seek medical knowledge from other transgender individuals over the knowledge of the medical establishment (see table 2). Bolin shows how support groups and social connections among transgender individuals serve as locations of information exchange. Transgender patients share information with other transgender individuals considering gender-affirming care. In doing so there is a large value placed on experience as a means of gathering information and knowledge over medical or academic studies. The importance of experience as a means of knowledge creation and understanding has been explored by anthropologist, Annemarie Mol (2021), as she extrapolates the ways in which the world is interpreted and understood by individuals and subsequently by social networks through interactions with the human senses. Patient social networks are no less important today than decades prior; however, the access to the internet has changed how transgender people connect and exchange medical knowledge. In-person support groups as a location of information exchange have been replaced by social media platforms, private groups, and message boards.

All but one (n=23) participants divulged the sources they used to gain information on gender-affirming care. This prompt was solicited from all but one participant who was
extremely loquacious in the initial couple questions. The following table shows the various sources of medical knowledge that patients in this study sought. There were five primary sources of information: other transgender individuals (n=18), internet sources (n=19), social media (n=13), medical staff (n=3), and other sources (n=2). Individuals could give more than one answer and answer more than once in any of the categories. Sources mentioned by individuals ranged from one to four per participant.

Table 2:

Sources of Medical Information Sharing

<table>
<thead>
<tr>
<th>Other Transgender Individuals</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Transgender Individual</td>
<td>n=18</td>
</tr>
<tr>
<td>At Support Group</td>
<td>n=4</td>
</tr>
<tr>
<td>At LGBT Center</td>
<td>n=3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Internet Sources (websites)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General Internet</td>
<td>n=19</td>
</tr>
<tr>
<td>Internet Search</td>
<td>n=12</td>
</tr>
<tr>
<td>&quot;Research&quot;</td>
<td>n=7</td>
</tr>
<tr>
<td>Google</td>
<td>n=7</td>
</tr>
<tr>
<td>Gender Dysphoria Bible</td>
<td>n=1</td>
</tr>
<tr>
<td>Wikipedia</td>
<td>n=2</td>
</tr>
<tr>
<td>Trans Bucket</td>
<td>n=1</td>
</tr>
<tr>
<td>“Academic Site”</td>
<td>n=1</td>
</tr>
<tr>
<td>Antijen (defunct)</td>
<td>n=1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Media</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Media (general)</td>
<td>n=13</td>
</tr>
<tr>
<td>Facebook</td>
<td>n=7</td>
</tr>
<tr>
<td>Facebook Group</td>
<td>Trans Nation</td>
</tr>
<tr>
<td>Redditt</td>
<td>n=4</td>
</tr>
</tbody>
</table>
As the table shows, information exchange among transgender individuals remains the primary way these individuals exchange medical knowledge. Few participants noted the provider or clinical staff (n=3) or a formal academic source (n=1) as their source of information regarding gender-affirming care.

Within these exchanges, transgender patients are sharing the following information: transgender patient experiences (=18), provider referrals (n=17), hormone types and dosages (n=9), surgical information (n=9), and support navigating insurance issues (n=4). The following quotes show these types of information exchanged by transgender individuals.

**Patient Experiences:**

[transgender individual]: I went to the only other trans person that I knew and I asked him, cause I had seen him go through his transition, sharing information and pictures on his Facebook and I just asked him, how do I do this? How do you transition [name]? And he pointed me to [health center]. I’ve been going there ever since. [Health center] is great, by the way.
[transguy]: So, and yeah, I’ve definitely, you know, but then within my social circle talked with people about just like, this was what my experience was. This is what you might look for. This is where you might start the search. For someone who’s gonna kind of fit your needs to work with your insurance and everything.

[transgender individual]: Honestly, the only education really, I got before I entered the medical system in terms of like finding a actual provider were always from the dolls, like other trans girls know someone that knows someone. Probably, usually a trans elder of some kind, but that’s be like ten years older or like fifty. They always have stories to share. They always talk about their experiences and that kind of bleeds into my life in terms of like, oh, I heard this person did this, and this person did this.

Provider Referrals:

DBH: How did you end-up connecting then with the surgical team for your top surgery?
[transguy]: Found, like, [doctor]. I was bitching to a friend of mine who’s in the [state] trans community, and he recommended a couple of resources. I think he actually laughed at me because I was being an idiot and obstinate. It was just like, no, here, go look at these and kind of just went through trans or trans accepting surgeons.

[transgender individual]: I asked people at support meetings that I was going to, you know, who do you see? Do you like them? What kinds of things have you had done?

[transgender woman]: I learned through my friends, and I wound up listening to them, I wound up going to [LGBT clinic] and filling out forms.

Hormone Type and Dosage:

[queer transgender individual]: But I’ve helped many a trans person come out. I’ve helped them get hormones. I’ve, in one case, given one of my friends testosterone when he ran out and his doctor couldn’t meet with him in time.

[transgender individual]: I met my first trans woman and I got to talk to her and about her life and feelings and her experiences. I was. I had that like angelic song moment of like the beam of light on me, and I was like, I. This is all too comfortably real and like I’m, maybe that means something to me. So, you know,
I was friends with her for a little bit and we would talk back and forth, and we talked about hormones, and what that did for her, and all of those changes were like really, overly, I wouldn’t think overly, really exciting but like, I’m happy for you, but like, oh wow, I’m happy for you, and I want it!

[transgender man]: I was just like, I can’t. I can’t, not do it and they offered me gel and I was like, I heard rumors that that doesn’t work fast, like, as fast as injections. I was like I want the, I want whatever’s fast. Fastest. Cause, I was like, no, I wanna look like a boy now.

**Surgical Information:**

[transman]: So, I also have spoken to other transmen about different surgeries. So, I actually had a few, well a couple, trans guys that I knew that had top surgery before I, I went and got mine, and they definitely helped me as far as like knowing, knowing where to go or what things I needed, aftercare and stuff like that. So that was very informative and helpful.

[transmasc demiboy]: One thing, as an aside, that I did was talk to my friend who has had a hysterectomy before and learn from his experience. There’s SO [participant emphasis] much more that I know now than I got from my gyno or anyone else I’ve interacted with so far. Again, using that network of trans people to learn more about the processes and things to be aware of regarding how one feelings before, during, and after the procedure.

[transgender individual]: And like, there was one person who asked me, like, what. They just asked a simple question; what are the cons to breast augmentation? I gave them zero pros and I listed about, I want to say, eight paragraphs of cons depending on the type of implant, the, the surgeon, the size, shape, material, under the muscle, over the muscle, nothing, just a laundry list of cons. I gave them and they’re like no positivity at all.

DBH: Yeah
[transgender individual] Actually, I think I did have one little thing that said, in spite of such cons, in my own experiences, definitely well worth it.

**Insurance** (see also chapter ten):

[transgender man]: I have given a lot of advice to trans folks who are struggling with their insurance providers. Like, I was part of the few, like, I can’t remember the name of it. It’s shut. It was like trans queer nation. It was like an online trans Facebook-ish vibe place and a lot of like. I gave some advice to folks that were on
[health system] insurance being like, here’s where you need to look in your policy to see if this care is covered. Because, here’s where I found it in mine and I’ve helped people read their policies.

[transwoman]: You know, but it’s the biggest constraint for everybody is money. I’m working with a girl right now who’s like, she, she makes too much to get on public assistance, to get on Medicaid, but not enough to afford health insurance that will cover anything. That’s so, we are trying to figure out what to tell her. I’m probably gonna tell her she needs to change jobs, you know.

This rejection of using medical literature and authorities when seeking information on gender-affirming care may be a result of continuing distrust of most medical providers as gatekeepers and antagonists to care, which has been mentioned in the background section, additional exploration on these views within the community could offer further explanation for this practice. Participants sought information from sources that they felt were most reputable. In the case of gender-affirming care, the most trusted resources were other transgender individuals. These individuals could assist in navigating medical options and alleviate challenges discussed and experienced in the community such as unwilling providers, insurance rejections, and lack of gender-affirming care resource networks endorsed by medical systems or the government.

Views on providers were mixed with participants expressing both positive (n=19) and negative (n=17) experiences with providers. Of these participants, 14 expressed both positive and negative experiences. Participants could give more than one answer and provided more than one answer. For positive interactions the range of responses ran from one to three indicators per participant. For negative interactions, the range of responses ran from one to seven indicators per participant.
Table 3:

Indicators of Positive Provider Interactions

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Communication</td>
<td>n=10</td>
</tr>
<tr>
<td>Provider Listens</td>
<td>n=4</td>
</tr>
<tr>
<td>Non-Technical Language Use</td>
<td>n=3</td>
</tr>
<tr>
<td>Affirming and understanding</td>
<td>n=6</td>
</tr>
<tr>
<td>Patient Choice</td>
<td>n=5</td>
</tr>
<tr>
<td>Knowledgeable</td>
<td>n=4</td>
</tr>
<tr>
<td>Asks Name and Pronoun</td>
<td>n=3</td>
</tr>
<tr>
<td>Not Rushed and Gives Time</td>
<td>n=3</td>
</tr>
<tr>
<td>Cares</td>
<td>n=1</td>
</tr>
<tr>
<td>Ease of Scheduling</td>
<td>n=1</td>
</tr>
<tr>
<td>Asks for Consent</td>
<td>n=1</td>
</tr>
<tr>
<td>Asks about Language Use</td>
<td>n=1</td>
</tr>
</tbody>
</table>

Table 4:

Indicators of Negative Provider Interactions

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refill/Prescription Issues</td>
<td>n=8</td>
</tr>
<tr>
<td>Refused Care/Referrals</td>
<td>n=6</td>
</tr>
<tr>
<td>Scheduling Issues</td>
<td>n=5</td>
</tr>
<tr>
<td>Ignored Needs</td>
<td>n=4</td>
</tr>
<tr>
<td>Misgendered</td>
<td>n=5</td>
</tr>
<tr>
<td>Strung Along</td>
<td>n=2</td>
</tr>
<tr>
<td>Frustrated/Disappointed</td>
<td>n=2</td>
</tr>
<tr>
<td>Non-Attentive Care</td>
<td>n=2</td>
</tr>
<tr>
<td>Provider Lacked Experience</td>
<td>n=2</td>
</tr>
<tr>
<td>Provider Awkwardness</td>
<td>n=1</td>
</tr>
</tbody>
</table>

Positive interactions were those where the provider was described as a good communicator, understanding, affirming, knowledgeable, and allowed the patient to have choice in their care. These positive indicators suggest that positive provider interactions are influenced by a sense of working together as a team to address gender-affirming care rather than a fully provider or patient driven interaction.
Negative interactions highlighted issues around accessing the desired gender-affirming care, especially prescriptions. A quarter of participants (n=6) mentioned being refused care and even referrals to care from providers. Other indicators of a negative interaction included feeling ignored, being misgendered, and challenges in scheduling a medical visit. These negative indicators suggest a refusal of patients to be seen as objects. Rather the transgender patient is an active and knowledgeable participant in their care.

Mol notes, in *Care: Putting Practice into Theory*, that, “Social scientists have often insisted that professionals should listen to their patients and talk with them, rather than just silently using diagnostic techniques and handing over prescriptions (2010, 10),” When accessing gender-affirming care, not all providers will work as a team with their transgender patients and this necessitates the transgender patient to take a more active role advocating for their care within the clinical space. Transgender patients learn to advocate for themselves from the success stories of other transgender individuals and how to speak up to providers to access the care and changes they desire. Annemarie Mol looks at the active role of patients in their care when it comes to managing diabetes in *The Logic of Care* (2008). She notes that, “Professionals in a consulting room can do no more than attend to people who define themselves as being in need of care. People, that is, who take care of themselves. Health-care practices depend on active patients (2008, 83).” In describing active patients, Mol is focused on patients following medical advice and seeking care. Mol is not discussing patients dictating specific medical interventions and dosages to providers, nor does she suggest that this would be a goal in medical practice. For Mol, “Within the logic of care bodies are not trapped in causal chains. Rather, they are embedded in treatment practices (2008, 44).” These practices within
gender-affirming care may include making and arriving at appointments, meeting the
diagnostic criteria, letting pills dissolve under the tongue, injecting hormones into the
body, and applying topical gels. Additionally, transgender patients are much more active
than other patients, often dictating the specific care they desire and seeking professionals
who will provide that care. The transgender patient is often working with more medical
knowledge about their needs than the provider they are seeking care from. This is
particularly evident when a provider has worked with few or no prior transgender
patients. The imbalance in knowledge unsettles the idea that, in clinical interactions, the
medical provider is the expert and the patient is a docile body to be practiced upon.

Jean Langford (2007), outlines the ways in which Western biomedicine sees
patients as “passive bodies of modern anatomy (377).” This is portrayed in contrast to
viewing bodies as living and moving bodies, “fluent bod[i]es, coursing with climates and
appetites, messages and passions, winds and tempers (376).” Within the medical
literature on gender-affirming care, the body becomes an object. Photographs and
drawings of surgical procedures are relegated to the treatment areas (groins, breasts,
arms), and when faces are shown the eyes are often censored, presumably to protect
patient privacy. Full bodies may be shown on the operating table with their arms, legs,
and face covered, only the surgical site exposed. Nowhere is a patients name present or
any indication of them as a person. Transgender patients, while having deep medical
knowledge, did not gain this knowledge through medical training, and thus, are not
entering their own discourse from the medical gaze. They see their bodies and the bodies
of other transgender patients as coursing with meaning, experiences, desires, and
sensations. This disconnect in how the body is viewed and understood may lead to awkward or uncomfortable interactions within the clinical space.

Gender-affirming care continues to be enacted in the U.S. despite a slow updating to diagnostic criteria, care standards, and binary gendering classifications within hospital practices, noted in the history of gender-affirming care located in the chapter three. Providers and patients arrive in the clinical space with varying degrees of knowledge around transgender experiences, healthcare needs, and medical practices. Yet, despite these variances providers and patients can work together to establish their end goals and enact care to move the patient toward those goals using the medical knowledge of both patient and provider to guide the process. As Mol notes, “Fixing the target of a treatment before the treatment begins just cannot be done: establishing a target is part of treatment (62).” It is in setting these targets where flexibility from the diagnostic criteria and care standards of the institution may be justifiable.
Chapter 12: Conclusion

This research set out to understand how transgender individuals navigate accessing gender-affirming care by looking at how multiple ontological perspectives impact gender-affirming care and its perceived outcomes; how the social narrative of transgender is impacted by biomedical practices, and how transgender individuals gain and share biomedical knowledge related to gender-affirming care. A remote ethnographic approach was employed that collected patient data through semi-structured interviews and structured journal reports of clinical encounters. In-person interviews and observational methods that were originally proposed were not possible during the COVID-19 pandemic. Data was organized along the biomedical schedule for gender-affirming care which allowed for comparing ontological perspectives between biomedical professionals and transgender patients.

This work builds upon and situates itself within the anthropological work around documenting and exploring non-binary gender systems, including the U.S. gender category of transgender, as well as examining the biomedicalization of sex and gender.

Key Findings

Within the study, four key findings emerged from participant interviews. These findings include critique of the biomedical schedule; critique of the requirement for mental health letters to access physical care; exploring the role of the clinical space in care provision; and understanding where transgender individuals access information about care options.

The Biomedical Schedule
The biomedical schedule follows a sequential process that starts with mental health interventions, then allows for the initiation of hormonal interventions, and finally allows for surgical interventions (see chapter four). This process is designed to start with minimally invasive procedures that are more easily reversed, progressing to more invasive and less reversible interventions. The structure is also informed from a model in which individuals are expected to transition from male-to-female or female-to-male, leaving out considerations of those whose gender identity falls outside of the binary or may not be seeking to attain the gendered body expectations of either man or woman. For example, not all transgender patients seeking top-surgeries desire hormone therapy. These individuals are often not given this option, as hospital systems and providers often require a patient to be on hormones before allowing a patient to access gender-affirming surgeries. Nearly a third of participants (n=7) expressed that they desired more autonomy in the decisions related to their gender-affirming care, and some (n=3) felt they were pressured by providers into receiving services that they did not desire.

The Letters

The largest area of disagreement with gender-affirming care was related to the perceived gatekeeping role of the requirements for a therapist’s letter to access physical care (see chapter five). The current WPATH Standards of Care, version 8 (Coleman et al. 2022), has maintained a recommendation that transgender individuals receive a letter confirming a locally defined diagnosis in order to access gender-affirming care surgeries. Over half of the participants in this study disagreed with the requirement for a mental health letter to sign off on physical care (n=13). The primary framing of this requirement by patients is that it is an unnecessary gatekeeping step that only serves bureaucratic or
legal means. This letter operates differently than mental fitness letters related to some physical care (bariatric, death with dignity) in that the mental health provider is also performing the diagnosis, whereas with these other areas the diagnosis is still within the realm of physical medicine. The letter requirement is deeply enmeshed with the diagnostic criteria. The WPATH endorses the use of local diagnostic criteria for gender dysphoria.

The DSM-V (American Psychiatric Association 2013) serves as a local means of diagnosing transgender patients in the U.S. For patients to meet the diagnostic indicators for gender dysphoria they must meet a mental health provider’s criterion for clinically significant distress caused by their gender incongruence. This can be highly interpretive and remains influenced by previous iterations of the DSM (American Psychiatric Association 1994, 1987, 1980). Nearly half of the participants in the study (n=11) felt that the current diagnostic criteria were inadequate to describe their experience and that their narrative had to be altered to meet diagnostic criteria. Additionally, a fifth of participants (n=4) felt that a previous mental health provider had strung them along with no intention of writing a letter (n=4). This has major implications for gender-affirming care as the mental health diagnosis is required by most providers to access physical gender-affirming care procedures.

The letters can also create delays in care depending on requirements that letters be issued within a certain amount of time in relation to the treatment sought. This means that if there is a surgical delay due to scheduling conflicts, need for weight loss, need for electrolysis, or a global pandemic, a patient may have to seek new letters to follow through on surgery. Other patients may have started transitioning via the black market
and view these requirements as pointless as they are seeking hormones which they may already have been taking for months or years. WPATH sought to address some of these concerns, but stopped short of suggesting an informed consent model, and only reduced the number of mental health provider letters from two to one (Coleman 2022).

Patients’ views around the letters are generally negative and seen by participants as a means of having to prove to a stranger that they are in fact who they say they are. This is not a general challenge to mental health as participants in this study were supportive of mental health as part of gender-affirming care delivery (n=13), but not in the role of a gatekeeper. Within my study a third (n=8) of participants reported specifically seeking a care provider who operated on an informed consent model as a means of avoiding “gatekeeping”.

Clinical Setting

Within the clinical setting, participants reported a near-even split of both positive (n=19) and negative (n=17) interactions with care providers, with fourteen participants expressing experiences of both positive and negative interactions with providers (see chapter eleven). Patient indicators of positive interactions with providers included: good communication (n=10), provider being affirming and supportive (n=6), and patients having a stronger choice in their care (n=5). Negative indicators with providers included: difficulty in obtaining or refilling prescriptions (n=8), refusal of care or a referral (n=6), being misgendered (n=5), and scheduling issues (n=5). Positive indicators are related to patient-provider interactions and building rapport. Negative indicators are a mix of systemic issues (refill issues and scheduling) and barriers that may be experienced by transgender patients (refusal of care, misgendering).
Within this study two-thirds of the participants sought care from LGBTQ clinics (n=16), which were structured as LGBTQ care networks across hospital departments and practices. However, with the exception of one participant whose care was received at a community-based clinic, there were no indicators in the physical space that a given department, practice, or doctor’s office was a safe and welcoming space. Typical indicators of welcoming space often include queer symbols, flags, or the presence of queer-oriented resources. Over half of the participants (n=13) reported a lack of LGBTQ indicators in their care space. Of these, ten were receiving their care from a clinical network that was specifically marketed for LGBTQ patients. Clinical spaces across practices were described by terms such as plain, white, and sterile.

Interactions in the doctor’s office were also heavily influenced by implicit actors. Some participants (n=4) noted the greater political climate as impacting their care decisions, others mentioned family pressure (n=2) or religious activism (n=1). Insurance was mentioned as an influencing factor by most of the participants (n=21). Twenty participants reported delaying or postponing indefinitely some aspect of their gender-affirming care due to insurance issues or costs. One participant expressed that their insurance provided access to some care, but limited access to other procedures. Only one participant expressed that their insurance acted as a facilitator for accessing their gender-affirming care. These external factors penetrate the constructed barriers of the clinical space and play active parts in patient-provider social interactions.

In addition to the doctor’s office, the receptionist and waiting area was mentioned by two-thirds of participants (n=16). There was an even split as to whether the interactions at the receptionist desk were a positive experience (n=8) or a negative
experience (n=8). Positive experiences were indicated by the use of correct names, pronouns, or being treated like any other patient. Negative experiences were indicated by deadnaming, incorrect pronoun usage, and looks or questioning that the study participants interpreted as offensive or triggering.

**Information Sharing**

Transgender patients have a large amount of biomedical knowledge around gender-affirming care which is shared among other transgender individuals through support groups and internet forums (see chapter eleven). Within this study, participants reported getting information on their care options from other transgender individuals (n=18), internet sources (n=19), and via social media (n=13). These individuals are seeking and sharing information related to patient experiences within gender-affirming care (n=18), referrals to facilitating or competent providers (n=17), information on hormone types and dosage (n=9), surgical options (n=9), and navigating insurance (n=4). The participants in this study rarely referenced seeking gender-affirming care information or knowledge from academic literature (n=1) or clinical staff (n=3).

The lay knowledge is shared to assist in navigating the gatekeeping steps of the gender-affirming care process, to share success stories for self-advocacy within biomedical systems, and to recommend sympathetic or facilitating providers. Transgender patients also share negative biomedical experiences, and may actively discourage individuals from seeking care from specific providers or medical systems.

**Anthropological Contribution**

Anthropology has a long history of studying human gender systems and human understanding of the body. The documentation of various gender systems and gender
identity categories outside of the dominant binary man and woman model was an important contribution to understanding gender as a social construct apart from biology. These alternate gender categories, while documented, were not the focus of these studies beyond the role of these gender categories within the larger society where they were expressed. Anthropologists such as Anne Bolin (1988), David Valentine (2002, 2007, 2011), and Eric Plemons (2017) have engaged in explorations of U.S. transgender populations and their interactions with biomedical systems and practices. My research situates itself within the study of non-binary gender categories and adds to the data compiled around the transgender population in the U.S. This is particularly important due to the increased call for restrictions on gender-affirming care and acceptance of transgender individuals within U.S. society. My research contributes to these works in expanding the understanding of transgender individuals, particularly in relation to their interactions with biomedical gender-affirming care.

The biomedical practices of gender-affirming care provide an opportunity to look at how gender is understood within U.S. society in reference to the physical body. From explorations into sex reassignment in the early 20th Century to the current practices outlined in the WPATH Standards of Care (Coleman 2022), the role of biomedicine in regulating sex, gender, and the body has been situated within the broader practices of medicine. Advancement of gender-affirming care practices is reflective of the U.S. cultural values of individualism, power over nature, and advancement through technology and science. In the U.S., there have been various gatekeeping moments in the delivery of gender-affirming care, and an overt focus toward gender-affirming care that seeks to transition an individual into a more-or-less normative man or woman.
Through the research presented, I have brought forward the experiences, understandings, and feelings of transgender patients within various levels of gender-affirming care. This has been structured in a way to be inclusive of the diverse ways in which transgender identities are expressed in the U.S. The purpose of compiling these data is to inform the practices of gender-affirming care; to better the biomedical experiences and outcomes for transgender patients; and to explore the ways in which the biomedicalization of sex and gender has framed the transgender patient. Transgender patients interact with medical systems in order to access the care they need to reduce gender dysphoria. Despite the reframing of cultural dialogue around sex and gender as independent categories, sex and gender remain deeply linked within U.S. culture, and primary and secondary sex characteristics are imbued with gender expectations and meanings. As a result, these characteristics remain social indicators of gender for many and can contribute to misgendering and/or dysphoria for transgender individuals. This work builds on the work of anthropologists exploring the process of biomedicalizing sex and gender in the U.S., specifically exploring the impact on transgender patients and the ways in which patient views and understanding have diverged from biomedical views and understanding. Additionally, it frames the clinical space as a location of social interaction and explores the ways in which patient and provider interactions structure the individual understandings of transgender and enact the practices of gender-affirming care.

Limitations

This study had limitations that were the result of the COVID-19 global pandemic. The first limitation was that observational studies in clinical spaces were not possible. This was addressed through the use of structured journals reporting on clinical encounters.
as a remote method. This method had mixed results. Some participants completed this with detailed descriptions while others answered with short responses. An interview was used to expand on shorter answers, but it is challenging to know what a researcher’s observations would have been in this space. Conversely, this presented the opportunity to gather information on the elements that the participants felt were important to their visit rather than being filtered through the observer. The second limitation that resulted from the pandemic was difficulty in recruiting transgender individuals who were not involved in biomedical gender-affirming care. Initial research designs sought to connect with these individuals via recruitment from support groups. However, during the pandemic, many support groups ceased to formally meet or shifted to virtual formats that made it more challenging for new individuals to drop in and presented challenges to access for those impacted by the digital divide.

Apart from the limitations presented by the pandemic, this study did not include gender-affirming care practices that were not part of biomedical gender-affirming care. These practices include black-market procedures, such as street silicone injections and hormones accessed through alternative means. The study was limited to adult patients and did not include individuals under the age of 18.

Due to the above-mentioned limitations, the results of this research should not be generalized to apply to non-biomedically involved transgender individuals or youth without further research within these populations.

**Next Steps and Future Research**

The research opens the door to furthering research into a critical examination of gender-affirming care practices. Potential future studies may incorporate non-medically
involved transgender individuals or seek personal views from gender-affirming care providers and compare these against the medical and social narratives of transgender.

As noted in the Limitations section above, this study did not delve into discussions of black-market gender-affirming care and focused on formal biomedical interventions. Exploring the role of these procedures both as separate from and influenced by the practices of biomedicine may offer a more expansive understanding of views on gender and biomedicine within the transgender community.

Additionally, the gender category transgender is a heterogenous catch-all that has served categorial and political purposes, but fails to fully encompass the wide range of gender identities and expressions within this group in U.S. culture. The study of gender would benefit from exploring these sub-identity categories and applying that to the broader cultural understandings of gender in the U.S.

**Clinical Implications**

Based on the information gained from participants within this study, several implications and suggestions for bettering the patient experience within the biomedical delivery of gender-affirming care presented themselves. These implications and suggestions address concerns that were raised in patient statements during the course of this research.

I found that transgender patients would prefer a more individual and tailored approach to gender-affirming care, where the provider and the patient work together in a logic of care (Mol 2008) model to determine treatment goals and recommended biomedical interventions. These discussions should include clear communication about limitations regarding patient choices, such as the need for hormone replacement therapy.
following a gonadectomy; however, they should also include limits of current medical training or knowledge. The requirements for hormone therapy to access top-surgery warrant additional medical study to develop procedures and practices that can accommodate transgender patients who are not seeking to transition from male-to-female or female-to-male. The largest concern with the biomedical schedule that was raised by participants was the requirement to obtain mental health letters to access physical care.

Transgender patients view the letter requirements to access physical care as an unnecessary gatekeeping step. Shifting the role of therapy and mental health from one of gatekeeping to one of additional support should be explored as a possible reconfiguring of the current biomedical schedule. An alternative to the letters is an informed consent model. This model is challenging to implement for institutions in the U.S. where healthcare is still privatized and insurance companies often require the letters in order for gender-affirming care to be covered on their plans. Within this study, some providers would use informed consent models for hormone therapy, but require the letters for surgical interventions. Transgender patients appear to prefer an informed consent model that would allow them to make decisions about their healthcare with physical health providers and not require a mental health professional to serve as a gatekeeper to accessing that care. Informed consent models emphasize discussions between a provider such as an endocrinologist or surgeon about the patient's needs, intended outcomes, treatment risk, and treatment expectations. Informed consent does not equate to a patient receiving medical services on demand; rather it shifts the model from one of gatekeeping and medical control to one focused on provider and patient interactions and co-created treatment goals.
A move toward an informed consent model would aid in alleviating barriers to care for transgender patients and reduce the obstacles to navigating and accessing care. Some providers have begun to practice or advocate for this model in the U.S. (Cavanaugh et al. 2016). This model would also allow transgender patients to determine their level of transition by opting for surgical interventions, such as top surgery, but declining hormones. This would also move the medical practices of gender-affirming care away from one of binary gender assumptions, this phrase feels a bit awkward  of transgender patient treatment goals, to one where patients and providers determine treatment goals together. Current practices and procedures (see chapter three’s history of gender-affirming care) are deeply rooted in ideas of a gender binary where transgender and gender non-conforming individuals are seeking to transition from one binary identity category to the other and neglects the actual lived experiences and more expansive gender identities of their patients.

Within the delivery of gender-affirming care, the built environment of hospitals and clinics plays a strong role in the patient experience. Medical systems use a wide variety of terms that denote gender or sex within the practices of biomedicine. This can be seen in how medical practices are divided and how parts of a healthcare system are named. One of the most easily recognizable of these are spaces designated as men’s health centers, women’s hospitals, women’s clinics, etc. As noted in chapter ten, these spaces can be dysphoria-inducing for transgender patients who are relegated to these gendered spaces due to their sex-assigned-at-birth and the separating of specialties along gender lines. Other clinical spaces are not necessarily gendered in the naming, but rather in their practices. Clinical spaces such as obstetrics, gynecology, and urology are not
directly designated as gendered spaces, rather their practices and the ways in which medical systems separate these areas of practice lead to gender-segregated waiting rooms and patient populations. Sahmoud, Hamilton and Pope (2022) noted the historical importance of the emergence of women’s clinics and hospitals as means of addressing the needs of a traditionally marginalized gender category and they advocate for creating ever inclusive safe spaces for treating patients across wider ideas of gender and gender identities. These researchers also proposed ways to create more inclusive medical spaces for transgender patients such as rethinking the naming of clinical spaces, using patient pronouns, chosen names, and using patient or gender-neutral language when referring to anatomical parts of the body.

Within patient care, the use of correct pronouns and names when referring to patients is essential in building rapport and trust between providers and transgender patients. Asking a patient’s pronouns and name seem like small gestures, but make a huge difference in the transgender patient’s experience of the medical visit. In chapter eleven, patient indicators of positive and negative interactions with medical providers demonstrated that being seen and understood as individuals were indicators of a positive experience and being misgendered and ignored were indicators of negative experiences. Clinical staff should be asking and gathering information on pronouns and names and medical records should reflect these demographics. This can improve overall patient experiences within the clinical space and adjacent clinical spaces such as waiting rooms, scheduling, and billing.

Medical providers are not the only people that a transgender patient interacts with when seeking care (see chapter ten). Schedulers, receptionists, clerks, cleaners, security,
parking attendants, and nurses, among many others, are all part of the care experience. These individuals should all be aware of how to interact with patients and be trained to use the correct names and pronouns when working with diverse patient populations. When working in gendered clinical spaces they should also be trained on how to handle potentially tense situations between cisgender and transgender patients.

As hospital systems increase access to gender-affirming care and market these services to transgender patients, they should examine the ways in which the division of medical practices and the physical space may serve as either facilitators or obstacles for those patients. This may include additional training for staff around working with gender-diverse patient populations or rethinking the physical space where care is delivered. Removing gender expectations from clinical spaces labeled men’s or women’s care when the services contained in these locations are being offered to transgender patients will reduce dysphoria caused by misgendering when transgender patients must enter these locations. Changing the names of these clinical spaces alone though, still results in waiting areas that may be populated by solely women or solely men and creates stress for transgender patients. Creating mixed and universal waiting areas for multiple related care practices may alleviate some of these barriers, and should be explored as an option when constructing new medical facilities.

Medical spaces are often designed to be plain, sterile, and white. For minority populations seeking care, the addition of indicators (safe space stickers, flags, or targeted resources) serves to communicate that a location is safe and supportive. Indicating that a space, clinical or otherwise, is safe and welcoming for transgender individuals may be as simple as placing transgender or LGBTQ identifiers in the space. This might be
symbolized by the pride flag, transgender flag, pride progress flag, or the transgender symbol. It could also look like having resources for transgender patients prominently displayed among other medical resources. These indicators demonstrate to transgender patients that the clinical space is there for them and designates that space as one where transgender patients can feel safe and welcome. These indicators also act as counters to political and religious rhetoric that may be experienced outside of these spaces.

Transgender patients value institutions that are actively working to support them and meet their care needs. Being open and clear about a care provider or hospital system’s advocacy or support actions communicates to transgender patients that the clinical space is not seeking economic gain, but is a safe and informed care environment.

Within the broader climate, economic barriers for transgender patients are often related to employment concerns or insurance issues. Patient care navigators or case workers who are trained to work with transgender patients may be able to offer support in navigating insurance coverage and economic barriers to care. For a broader impact, hospital systems and providers, through professional networks and influence, can also advocate for their transgender patients by promoting the inclusion of gender-affirming care procedures as medically necessary and to be covered by more insurance plans. Lastly, due to patient knowledge and information sharing within the transgender community and a reluctance to seek information from medical providers. The findings suggest that additional research is needed to explore how patient and transgender views or experiences are incorporated into the development of diagnostic criteria and standards of care, including the impact this has on the perceived validity of these tools within the patient population. Further, this research suggests that hospitals and health systems may
benefit from bringing in transgender patients or individuals to assist in reviewing how the built environment including waiting rooms, the naming of clinical spaces, and the ways a lack of support indicators can impact the transgender patient experience. The findings of this research serve as a building block in exploring these policy and practice-related questions for gender-affirming care providers and will hopefully allow for the rethinking and restructuring of the ways in which gender-affirming care is understood and practiced in the U.S. to create a better patient experience for transgender individuals navigating this care.
Appendices

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**Participant Interview #1 Outline** [the term care or this care will be replaced by the point of care level i.e., this surgical procedure, or the endocrinology appointment, etc.]

**Participant Gender Background**

Please tell me a little about yourself?

Describe your experience with gender to date?

When do you experience dysphoria the most?

And when do you experience dysphoria the least?

**Gender-affirming care Process to Date**

Describe your transition to date?

What has your experience been like with the gender-affirming care process?

Would you change anything about your transition process?

What parts of your process have reduced your experience of dysphoria?

Are there any parts of your process that have triggered dysphoria?

**Current Gender-affirming care**

What does receiving this care mean for you?

What factors did you consider before entering into this level of care?

How did you find the provider of this care?

What are you hoping will be the result of this care?

Are there any concerns you have about this care?

**Future Gender-affirming care Goals**

Do you intend to engage in any other gender-affirming care procedures/services?

What is your hope for having these procedures?

**Medical Knowledge**
How did you learn about the gender-affirming care options available to you?

Do you believe that information on gender-affirming care is easy to find and understand? Why or why not?

Do you feel that you providers are competent to provide the care you need? Why or why not?

Have you shared your knowledge or experience with other trans folk?

Impact of Gender-affirming care on Life

How has your gender-affirming care to date changed you everyday life?

How has your gender-affirming care to date made you feel about yourself?

Has there been any negative impacts from your gender-affirming care to date?

Has there been any surprises caused by your gender-affirming care to date?

Recommendations for Others

If a trans person reached out for advice on transitioning, what would you tell them?

If a provider asked for your input on the transition process, what would you like them to know?

If there were no limitations what would an ideal process for gender affirmation look like?
**Structured Journal Prompts**

Describe your feelings before your visit:

Describe your feelings during your visit:

Describe how are you feeling now:

Describe the experience of arriving at the care setting and getting to see the provider:

What was the waiting room experience like?

What did the care setting look like? What things stood out to you?

What people did you interact with during this visit? How did they interact with you?

How did the interactions with these people make you feel?

Were there things that you didn’t understand that the provider told you, or procedures that they performed? Please describe these:

Were there moments where the provider didn’t understand something you were communicating to them? Please describe this experience:

How did the communication between you and the providers make you feel?

Were there any moments where you felt truly understood by your provider? Describe:

How did the procedures/medications make you feel?

What was the experience like for you to receive this service/product?

How did this visit impact your overall sense of gender/gender identity?

Would you recommend this service to another trans person? Why or why not?

Is there anything else you would like to share about this visit?
Participant Interview #2 Outline

These interviews will be heavily influenced by the responses collected in the participant’s structured journals and will seek to add information and clarity. There are not specific questions here, but a general outline to ensure that the researcher hit points of clarification and addresses research needs.

General Recap of the point of care visit:

Feelings associated with the visit:

Experience of the visit:

People (human actors) involved in the visit:

[If proper names were used, clarify role in order to anonymize in the transcription]

Feelings associated with interactions:

Experiences of interactions:

Things (non-human actors) involved in the visit:

[If proper names/places were used, clarify to anonymize in transcription]

Feelings associated with these things:

Experiences of interacting with these things:

Medical terminology and knowledge:

Provider/Patient Experiences:

Provider/Patient Feelings:

Overall experience:

Overall feelings:

Perceived impact of care provision:
Any additional comments or clarifications:
CODING SCHEME: Patients, Practice, and the Social Construction of Transgender

Clinical Space (medical office) Description:

Physical descriptions of the clinical space. Clinical space is the space in which the actual medical procedures are enacted. Waiting Rooms and reception desks are coded separately.

Waiting Room

Descriptions of the waiting room spaces. This includes physical space and other individuals occupying these spaces. Additionally, feelings related to this space are coded here.

Receptionists

Interactions with reception desks, kiosks, or other non-medical staff related to directing a patient to their appointment location or checking the patient in for their medical appointment.

Gendered Clinics (Women’s Center/Men’s Health etc.)

All forms of gendered clinics are coded here. This includes spaces designated as transgender clinics, women’s clinics, or gendered departments such as urology and gynecology. The code captures the feelings and experiences of seeking care in these spaces.

Insurance

All issues of payment for procedures were coded under insurance, whether a specific insurance issue was mentioned or not. This code also captures instances
of procedures or medications not being covered, or challenges in getting procedures covered by insurance providers.

Transportation

All mentions of transportation including parking and distances traveled are coded here.

Telemedicine

All mentions of virtual visits and telehealth are mentioned here.

DSM Criteria Mentions

All mentions of the diagnostic criteria are included here. Any mentions of having to prove oneself as transgender to a medical or mental health professional are also coded here.

Trans Therapy/Mental Health

All mentions of non-Gender Dysphoria relate mental health and therapy.

Gatekeepers

All mentions of gatekeeping or barriers caused by specific people or institutions to accessing or controlling the access to gender-affirming care. This includes insurance companies, therapists, doctors, surgeons, family, or political figures.

Therapist Letters

Views, feelings, and experiences related to the WPATH suggested requirement for therapist letters to be used in order to sign off on gender-affirming care.

Other WPATH References
Views, feelings, and experiences with other elements of the WPATH standards of care. This includes available procedures and various timelines and requirements for these procedures.

Trans Authority/Knowledge

All instances of knowledge sharing and community exchange of medical/health information between transgender individuals. Also instances of patients educating their providers.

Medical Knowledge/Experience

All instances of agreement with or disagreement with biomedical knowledge from a professional. Included here are instances of providers giving new biomedical information related to gender-affirming care to patients.

Informed Consent

Mentions and feelings related to the informed consent model for providing hormones, where providers do not require therapist letters, but rather rely on patients to give informed consent.

Hormones

Mentions of hormones and their impact or perceived impact on gender-affirming care. Also mentions of and descriptions of appointments with endocrinologists or hormone prescribing doctors.

Private/Cosmetic Procedures

Discussion of private providers or discussions of procedures that are considered cosmetic surgeries.

Penis
Mentions of penises were coded here.

Hair

Discussion of hair in all forms is coded here. This includes facial hair, head hair, chest hair, and body hair. Electrolysis mentions are also coded here.

Top Surgery

All discussion and feelings related to top surgery procedures. This includes mastectomies and breast augmentation.

Genital Surgeries

All discussions and feelings related to bottom surgery procedures. This includes orchiectomies, vaginoplasties (penile inversion and peritoneal pull through), metoidioplasties, clitoral lengthening, no-depth vaginoplasty, and phalloplasty.

Non-Binary/Trans Ideals

Mentions of ideal results of outcomes, both realistic and ethereal.

Reason for Transitioning

Mentions of core moments of realizing that the participant was transgender.

Provider Interactions

Good

Descriptions of positive interactions with care providers

Bad

Descriptions of less than ideal or negative experiences with care providers

Ideal

Descriptions of preferred or ideal interactions (these are suggestions or ideals that the participant did not express experiencing)
Transition Advice

Advice that would be given to another transgender person regarding transition

Memorable Quotes

Any specific quote or sentence that stood out and would make a good quote.
Reflexivity Statement

The first formal question I asked all of the participants of this study was immense. It was simply a request to describe one’s journey with gender to date. I felt this was an important question to start with and allowed the interlocutor to lead the narrative of their gendered experience in the world, prior to any prompting from me. As such, I believe it is also important to reflect on my own journey with gender to date, since this was a contributing factor in the direction of this research, the interactions with participants, and the interpretation of the data collected. As a result, I am going to be exploring my own brief journey with gender and queerness to highlight important messages and moments of reflection from my own experiences and contrast these with the social and historical positions of the times, and theoretical concerns. This approach to the reflexivity statement is modeled on the practice of autoethnography (Ellis & Bochner 2003, Ronai 1997, Behar 1996) and seeks to place myself as a researcher within the context of the research population to which I am also a member.

Autoethnography is a practice which brings the researcher (or a participant closely related to the researcher) into the analysis of data through personal narrative and reflection, posing the researcher as both authority and subject. While the role of the researcher is constructed as one of participant observer, ethnographic methods often emphasize the experience of being within or among a population. Autoethnography takes the concepts of reflexivity further by placing the researcher as both the object of research and the expert (Ellis & Bochner 2003). I was first draw to this method after reading Carol Rambo Ronai’s essay “My Mother is Mentally Retarded (1997)”, which wove the
personal experiences of mental health and child abuse along with the professional and academic analysis of these experiences in relation to the data. This positionality of the researcher as subject creates a vulnerability that can be difficult for objectivity; however, when done well, serves to bring colleagues and researcher closer to the subject. In *The Vulnerable Observer* by Ruth Behar (1996), this vulnerability is explored both from the point of experiences of the researcher, and the the impact professionally of publishing these types of works and the vulnerability created by analytically exploring moments that may have been traumatic or emotionally challenging. However, this difficulty can also be cathartic and healing, as one can explore their own self from the perspective of an outside observer and gain new meanings or insights into those moments. In this manner, I hope to engage my own journey with gender to date, in order to place myself as an actor within this study of transgender and queer identities, as well as give the reader knowledge of my positionality among the research population.

In 1969 the modern gay rights movement was born in the United States when a police raid on the queer establishment, Stonewall Inn, in Greenwich Village, New York City was met with unexpected resistance from its patrons. This resistance quickly ignited into a multiday series of riots and served as a unifying catalyst for activists to come together around gay and lesbian rights. By the time I was born, there was a solid narrative of what it meant to be gay, lesbian, or bisexual. Gender, gender expression, and gender identity were always a core component of the gay and lesbian narratives I was exposed to; however, I was not made aware of transgender or gender variant identity categories, apart from being linked to non-heterosexual expressions until much later in my life. This
historical note serves to function as a landmark of the era into which I was born and the socio-political climate around topics related to gender identity and sexual orientation.

I was born in the mid-1980s, a few years after the DSM-III (1980) was released, which marked the removal of homosexuality as a disorder. This edition of the manual was also where gender identity disorder would be added. The broader social and cultural impact of these changes is explored in the Background of this dissertation. For me, this placed my early childhood in closer relationship to understanding of queerness as deviance, rather than as an accepted social category and impacted the amount of time it took for me to come-out to myself and to others.

An icebreaker activity in some safe zone and LGBTQ+ sensitivity trainings ask participants to reflect on their earliest messages received about the LGBTQ+ community. For me I distinctly remember riding in the car while my mom was driving and talking about a family friend, when my brother shouted from the backseat that Mr. X was gay. I remember feeling uncomfortable in that moment, something struck me, that I was not “normal.” The message was the reaction my mother had to my brother’s teasing statement. She looked into the rearview mirror and just said flatly, “Mr. X is a good person.” With that defusing maternal statement, I read quickly that gay must be bad for her to declare so adamantly that this man was a good person as a defense to someone calling him gay. I wondered, if I was gay, what would people say about me?

In reflection, I knew I was not straight during my teenage years. I struggled hard to not let it be known or act on these feelings throughout my middle school and high school years. When I was fourteen, a major cultural moment occurred that I reflect on
heavily in relation to ideas of coming-out. This moment was the infamously known “The Puppy Episode” (1997) and saw Ellen Morgan, portrayed by Ellen DeGeneres, come-out as gay on the show and then the actress would subsequently come-out as gay in real life. This moment would launch a succession of high-profile coming-out moments, as well as a social and political emphasis on the act of coming-out as a political maneuver in the continued attempt to gain equity and rights for lesbian and gay individuals. This was less successful for bisexuals or binary ambiguous sexual orientations, as evidenced by the attacks from all sides on the former partner of Ellen DeGeneres, actress Anne Heche. My grandmother, possibly unaware of my internal struggles with sexuality, noted while watching the news, “the name DeGeneres fits her.” Suggesting that she was a degenerate.

Throughout my life, the act of coming-out was deeply tied to politics. Lesbian, gay, bisexual, transgender, and queer individuals were encouraged by activists to come out. In doing so, we would show our numbers, build support, and be seen as more normal than the protection of secrecy and silence allowed. This was framed as a deeply personal decision and move, however, in practice it was a very public and political act. The power of coming out was one that was espoused throughout gay circles. It seemed like everyday a new celebrity or person of influence was being outed or choosing to come-out. While there was power in these acts, there was also great risk. For many these moments led to loss of employment, family, support, wealth, and/or power. We were told to stick it out, and that it gets better, but it doesn’t always. Coming out doesn’t fix all of our problems, but it takes the burden of hiding in the closet off the table, and that is liberating in a way that is difficult to put into words. It opens a world of possibilities and allows for dreams of new potentialities.
I wouldn’t come out to myself until college. I poured myself into school activities, religion, and work. I deflected heavily from any discussions of sexuality and gender. I rebuffed anything that I thought might lead to me not being cisgender and straight. This included clothing, reading material, and people. While I fit in well, I felt deeply isolated from my peers. There was another student in my high school who was rumored to be gay. It came to be known that he had a crush on another male student and the rumors, teasing, and bullying led to him transferring schools. It was not a safe place for anyone to be different or come-out. I graduated top of my class, lettered in track and field, and had an extensive extracurricular curriculum vitae. In college, I actually met gay and lesbian students and realized that they were not making choices, but just were attracted to specific qualities in others that were defined as relational to gender and gender expression. It was during this time that I came out as bisexual and began to date men and women. I never joined the campus gay/straight alliance, and didn’t always feel like I fit-in in gay spaces. I identified heavily as a bisexual, with a car length bi-Pride flag bumper sticker across my ‘85 Buick LeSabre and was a regular in bisexual chat rooms. I dated a girl who was also bisexual and we enjoyed an open relationship with other individuals and couples for several years. Eventually, we parted ways and I met my husband and brought him home. My grandmother took me aside and informed me that she thought I would marry a woman and have male lovers on the side. For her, this was an acceptable manner of performing queerness without having to “come out”. I let her know that the chips would fall where they fall. She always did say I danced in the grey area of life. She was not wrong.
The social expectations related to marriage, family, and sexuality around this time were heavily influenced by a rapidly changing social and political climate around queerness. Sodomy laws in the U.S., which were enforced as tools to punish queer consensual relationships, were overturned in the U.S. 2003 Lawrence v. Texas decision. This laid the groundwork for the repeal (2010) of the 1994 Don’t Ask Don’t Tell order (U.S. Department of Defense Order 1993) in 2011, and the eventual recognition of same-sex marriage in 2015 following the Obergefell v. Hodges (2015) decision, which overturned the Defense of Marriage Act (1996). This rapid-paced change was, in part, a legacy of the coalition building among the LGBTQ+ community that started at Stonewall, but received larger support and funding to combat the HIV/AIDS epidemic throughout the 1980s and 1990s. As HIV/AIDS shifted from a death sentence to a manageable disease, focus within the queer community shifted from short-term goals to lifetime needs. The focus moved toward attaining a series of basic civil liberties and opportunities across the community. After the attainment of same-sex marriage nationwide, focus from marriage equality organizations began to explore the LGBTQ rights which had been placed out of focus, particularly the rights of transgender individuals. Transgender rights and marriage equality were two sides of the same bargaining chip that many state-level organizers had to decide which to focus on and compromise on the other. Marriage equality would prove to be the flashier and more popular fight.

The control of sex and sexuality by the state has been detailed by Michel Foucault in his “The History of Sexuality (1980)” series as he explores the ways in which production, labor divisions, and wealth are tied to state and culture. The means of
controlling labor were both societal and individual, hence the regulations on marriages, families, and inheritance were created and maintained. Queer life challenges these normative and controlling modes of production by rejecting the status quo and reproduction of wealth and labor in society. In J. Halberstam’s *A Queer Time and Place* (2005), we are led to explore the concepts of a social time where marriage, accumulation of wealth, and inheritance are not the goalposts of a life well lived and rather relationships, pleasure, and a here and now mentality thrive. This queer time, as it were, is further explored by theorist Jose Muñoz (2009), in the exploration of queer potentialities portrayed in queer literature and art, which suggests a mode of being and existence that is free from heteronormative control and allows for the visioning of a queer utopia. Muñoz also explores the ways in which new state sanctions on queer relationships, such as the legalizations of queer sexualities and queer marriages, can serve as both a move toward queerness and away from it, as heteronormative relationship structures are adapted to same-sex or queer couplings. This is a concern picked-up by Mattilda Bernstein Sycamore (2008) in the exploration of changes to queer places in various U.S. urban settings. She notes the ways in which a growing White middle-class normative gay aesthetic is gentrifying previously queer spaces and how they are becoming much more heteronormative in vibe and policy. J. Halberstam (2005) suggests that queer places are liberating spaces, where sexuality is freed and heteronormative social norms can be rejected leading to the social mixing of genders, races, and classes. The gentrification of previous queer enclaves, such as the Christopher Street Piers, are not occurring solely by state police and political actors, but also the wealthier and more privileged gays within the community itself.
The haunts of my college days, Tool Shed, Man’s World, Grid, Club Cleveland among others are gone. In their place now stand trendy restaurants, premium apartments, and small boutique stores. The sexually charged and liberating basements, dark corners, and parking lots have been replaced by landscaped sidewalks, young families, and hipster banter. It is great to see progress, but there was something lost here as well. I am set to be part of this change, as my partner and I are currently adopting and have moved to the suburbs chasing better schools and safer parks.

Beyond sexuality, when it came to gender, a revolution was brewing and gender was being reconceptualized as a social construct rather than a biologically determined concept, where male=man=masculine and female=woman=feminine, and any other model was deviant. This reconceptualization was heavily driven by the work of Judith Butler in _Gender Trouble_ (1990), which also paved the way for a great deal of queer and trans theory. Butler presented the argument that Feminism needed to expand beyond binary ways of exploring gender, particularly in relation to the ways in which womanhood and femininity were being studied. By separating gender as a social construct from the biological sciences of sex, transgender identities and alternative expressions of gender beyond the prescribed socio-political categories were given space to be seen and explored, not as deviance, but as normative expressions of gender within human societies. While Butler’s work on gender was groundbreaking for all genders, the primary focus was on the representation of women as political subjects, and the reimagining of this gender category that had served as a means of repression. The work did not lean into non-binary genders in its analysis; however, following critiques from scholars such as Prosser (2006), this omission was revisited by Butler (2004, 2006) and
has served as a primary argument used by transgender communities in their fight for equal access to employment, education, credit, housing, and public accommodations.

My future husband and I moved to Boston, where I began working in victim services assisting LGBTQ+ survivors of domestic violence to break away from their abusers and recover from the trauma of abuse. By volunteering and participating in community forums and task forces, I was introduced to the advocacy group, the Massachusetts Transgender Political Coalition (MTPC). It was at MTPC that I began to really start to feel like I found individuals who had similar struggles to me. These struggles were less about sexual orientation and more about gender identity. I began to explore how gender made me feel as I moved through the world and I slowly began to feel like I did not fit into the socially prescribed roles of either man or woman. Through MTPC, I would be able to come-out as transgender, as well as, adjust my own label for my sexual orientation and gender to better reflect how I move through the world. I now identify as queer for both social categories. It was learning that that was a possibility, and finding the label that was right for me, that helped me come out. I often describe my own story of coming-out as one of being given permission at different points in my life to step into and try on various queer categories until I landed on the one that is just right, for now. I feel most comfortable in mixed queer spaces that include representation across the LGBTQ+ categories or transgender specific spaces, though these are more challenging to come by.

Transgender narratives were heavily focused on “the surgery” and invasive details about genitals. I remember watching “Normal (Anderson 2003)” and seeing Hayden
Panterra’s character describing to her classmates the process her father was going to undergo for sex reassignment. It was graphic and played as a voyeuristic exploration of something strange and unusual, not unlike the daytime talk shows and late-night interviews where sensationalist hosts, as well as, respected journalists inquired into individuals’ genitals in front of mass audiences. In 2014, a shift occurred when transgender activists and celebrities Carmen Carrera and Laverne Cox were being interviewed by Katie Couric (“Money Myths Busted” 2014). Katie Couric returned to questions about the women’s genitals and surgical procedures several times and both Carrera and Cox maintained professionalism and dodged the questions. Then a pivotal moment in transgender narratives occurred when Lavern Cox schooled Katie Couric and America on why discussions of genitals were reductive and harmful, and how transgender people would like to be treated. The moment sticks in my mind, and the shift in media and style books across America was swift. This happened one year prior to the start of the series “I Am Jazz (2015-Present),” which follows Jazz Jennings, a transgender youth, in her daily life and struggles. This humanizing portrayal was a huge shift from emphasis on surgeries, sexual deviance, and tragedy. Jazz has become an activist and public speaker; her work is inspiring for those of all ages. For this reason, I was taken aback the first time I saw her at a transgender conference. She darted past me with all the exuberance of youth to ask her mother for money and I was reminded that she indeed was a youth. It was both refreshing and made me think about how queer youth have to be so mature and resilient so young.

Transgender theory is about narratives. Narratives have historically been used to describe, explain, diagnose, and control transgender individuals, communities, and
bodies. In her introduction to *The Transgender Studies Reader*, Susan Stryker (2006) notes the ways in which transgender identities and narratives had heavily been controlled by cisgender individuals, who though meaning well, were not representative of the gender diversity they described and studied. While transgender studies is heavily concerned with deconstructing the linkages between concepts of biological sex, social constructions of gender, and performativity of masculinities and femininities; it is also concerned with re-narrativizing concepts and highlighting narratives from within the community. Taking control of narratives is a technique of being a *gender outlaw* as Kate Bornstein (1994) notes. In a chapter titled, “Gender Terror, Gender Rage”, Bornstein explores the ways in which gender narratives can lead to tension and violence when expectations are disrupted, as well as the anger that cisgender and normative individuals can be driven to express when their concepts of gender are not met. This rage leads to acts of violence, including murder. This is evidenced by the growing list of dead observed each year on Transgender Day of Remembrance. A list that includes many individuals I have had the pleasure to have known, helped, and worked with. Observing this day has become harder and harder for me emotionally. The ability to narrativize one’s own experiences with gender is powerful, liberating, and risky. Jay Prosser explores this control and some of the challenges of separating one’s true self narrative from those imposed on the transgender community by the dominant power structures in his work, *Second Skins: The Body Narratives of Transsexuality* (1998). This work explores the narratives of the body that are expected by medical providers, family, and media and how transgender individuals’ narratives may fit or diverge from these
expectations. It highlights the importance of autobiography as a tool for telling and owning one’s own narrative.

I found a gay doctor in Boston and thought that was good enough. I suffered extreme pain for years and was told that it was psychosomatic and related to my conflicts with gender identity by my gay-identified primary care provider. I dealt with the preferred pharmacy regularly misgendering, and at times, refusing to speak to me on the phone. As one pharmacist, who did not put down the phone, said, “this cannot be someone born male, they are lying.” As happenstance would have, I was walking home one day when a Black transgender friend of mine, who was in the closet to protect the employment and social status of their spouse, pulled over and offered me a ride. I got in and was talking about my pain and my issues with the doctor. She immediately gave me the number of her provider, who worked at an LGBTQ Pride Clinic that offered transgender health services. I called the next day and made my first appointment. After describing my pain, I was sent to a specialist who discovered I had gallstones and following a simple surgical procedure, ended the years of grueling pain attacks. I learned that medical providers are not necessarily trained to work with all people and began to be a better self-advocate in the medical setting after that. Based on previous research with transgender patients and talking with friends, it is my experience that this is a common issue.

I am now engaged in research to explore the transgender identity in relation to the biomedical process of gender-affirming care. I have been socially and politically active in the community for over a decade and am a regular attendee of the Philly Trans Wellness
Conference, produced several years of Transgender Day of Remembrance in Lowell, Massachusetts, and have sat on the committee to produce Trans in the CLE in Cleveland, Ohio. Choosing to study a population to which I am also a member presents both challenges and benefits.

This approach to studying a community that one is part of or adjacent to was explored by Barbara Myerhoff (1980) in her ethnographic work conducted among aging Jewish individuals in California. In this example, Myerhoff was situated as both a member of the community, albeit not in age, and demonstrated the abilities to engage in ethnographic work closer to one’s own community rather than seeking answers in solely the exotic. This method also allowed Myerhoff to engage deeper with reflexivity and her positionality as a researcher, as she was pushed to navigate her own feelings and expectations for her future. I do want to pay homage here to two early anthropologists who engaged in anthropology within their own community prior to the move toward focusing on reflexivity. They served as cultural interpreters and academic scholars, and were able to access and document speech patterns and cultural notes that other anthropologists may not have been as successful with. They are Zora Neale Hurston and Ella Cara Deloria. It is these two researchers, Black and indigenous North American (Dakota, Sioux), who inspire me to tell my community’s stories and to uplift their voices in the academy. They also serve as a cautionary tale about funding, power, and academia for minority and in-community researchers with regard to the risks of exploitation from powerful institutions and devaluation of minority in-community research as less than.
I will be using the term “in-community research” to define research conducted by someone within their own community, or identity population, in place of the term “native anthropology,” a term which places anthropological practices in line with colonizing and imperialist practices still present in the field today. This method will also highlight the power inherent in non-dominant communities of study to engage in their own documentative and analytical work. By engaging in in-community research, one can find greater access to participants due to trust or preexisting relationships. However, there are also risks. Judith Stacey (1988), in critiquing the methods of anthropology in reference to feminist ideals, presents that ethnographic methods as practiced can run counter to the values of feminist scholarship. She notes that ethnographic methods may lead to “exploitation”, “betrayal”, or “abandonment of research subjects”. Engaging in research within one’s own community reduces the risk of abandonment of research subjects following the end of a project or end of funding; however, the risk for exploitation and betrayal may be increased, as research participants may let their guards down. It is essential then for the researcher to always be aware of this and check for shifts in tone, establish research boundaries, and be honest with participants at all times. The researcher should also be acutely aware of the relationships with their participants and ensure that friendship, familial, or social obligations or expectations are not filtering into the decisions of participants to participate in ways that are coercive. In order to reduce this, I regularly reiterated to participants who I had pre-existing relationships with that the interviews and tasks were completely optional and not to do them as a favor to me. While no one dropped out of the study, I know this worked well even in advertising as some friends who have engaged in previous research projects did not elect to participate in this
one. Maintaining time to reflect on impact is important on both the individual and the community level. For an in-community researcher, one is constantly aware of their potential impact, as the impact is both personal and general. It is through these lenses and lived experiences that the study design, methods, analysis, and dissemination plans were drawn for this project.

The study was designed to focus on the patient narratives of transgender individuals seeking gender-affirming care. There is a wide published discourse on the biomedical views on gender-affirming care for transgender individuals. I used this discourse to pull in medical knowledge, but chose to emphasize the lesser captured experiences and knowledge from transgender patients. My lived experience as an attendee at support groups and socializing among other transgender individuals fostered my interest in how our community navigated balancing their own experiences and narratives with those expected and required by biomedical systems in order to access care. The initial questions were kept broad to allow participants to establish the language around gender and care treatments. I also kept a focus on the experiences and understanding of the patients within the biomedical system. The lens for analysis was critical and structured on the biomedical schedule, allowing a clearer picture to develop on the aspects of gender-affirming care that held the most dissonance between provider and patient perspectives. It is my hope that I can contribute to supporting and uplifting my own community through this and future research, and that my journey will inspire others to contribute in their own ways.
Bibliography


Huang, Kathy. (2011). Tales of the Waria. Tribeca Film Institute and CAAM. 57 minutes.


Mahalingam, Ramaswami. (2003). *Essentialism, Culture, and Beliefs About Gender Among the Aravanis of Tamil Nadu, India*. In *Sex Roles*. Springer Nature.


Zimmerman, Don H. (1992) *They Were All Doing Gender, But They Weren't All Passing: Comment on Rogers*. In *Gender & Society*, vol 6, 2. SAGE Publications.